



Abt Associates Inc.

Final Report

Evaluation of High-Risk Pools

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1. Overview of the Report

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Centers for Medicare and Medicaid Services (CMS) is responsible for reviewing state compliance with federal law governing access to non-group health insurance. An increasingly common method of state compliance is to create a high-risk pool, through which state residents who are unable to obtain insurance from private carriers (usually due to health status) may obtain individual coverage at premiums that are capped at some multiple of the private market rate. To improve the government's capacity to carry out its oversight role, CMS contracted with Abt Associates¹ to answer a number of questions about high-risk pools, concerning operations, sustainability, and potential for improvement. These questions included:

- How do high-risk pools work?
- Do high-risk pools provide access to health insurance for those who need it?
- How do high-risk pools and state Medicaid programs coordinate their activities?
- What factors contribute to the sustainability of high-risk pools? What factors contribute to instability?
- What impact did HIPAA have on high-risk pools?
- Is insurance through high-risk pools affordable?

Although data limitations prevent definitive answers to many of these questions, this report provides an overview of high-risk pool operations, an analysis of available data, and a foundation for future investigations. The major themes uncovered during this project and discussed in this report are as follows.

- Funding is the single most important issue facing high-risk pools. Since high-risk pools are designed to insure chronically ill, privately uninsurable individuals, they all run deficits and need to fund approximately half their claims through some means other than premiums. Per enrollee deficits are increasing in all states and the rate of increase is very steep in most states.
- Cost-containment efforts vary widely from state to state. In general, larger and more urban states have better access to managed care and have implemented more sophisticated cost-containment strategies.
- Access is one of the most important issues facing potential high-risk pool enrollees. While all states that use high-risk pools as the HIPAA alternative mechanism cannot (and do not) impose an enrollment cap for HIPAA enrollees, some states impose caps for all other types of enrollees due to funding limitations. Even without explicit caps, however, application processes can be cumbersome and marketing efforts are severely limited.
- Despite the passage of HIPAA, affordability continues to be an obstacle to improved access to health insurance through high-risk pools. States with relatively low premium caps or subsidy programs for lower income enrollees have experienced substantial increases in demand for coverage, suggesting that high-risk pools could insure a larger fraction of the uninsurable population if their premiums were lower. Our estimates suggest that if additional financing were available, high-risk pools could easily expand by

¹ The project name is "Evaluation of High-Risk Pools" (Contract No. 500-95-0062-0008).

20 or 30 percent, from enrolling approximately 7 percent to approximately 9 percent of the uninsurable population.

Each of these themes is developed in more detail in the body of this report. The report is organized to reflect the different research methods that were used as well as the different questions the Project Team was charged to answer. After reviewing some general background on the project in general and data sources in particular in the next chapter, we present results from our qualitative analysis of operations, institutional relationships, and pool sustainability in the following four chapters. Chapter 3 provides an overview of themes that have emerged from the qualitative data gathering, including a particular focus on access issues. Chapter 4 describes the relationship between high-risk pools and state-financed health insurance, including the Medicaid program. Chapter 5 discusses some key states with high-risk pool histories that shed light on the issue of sustainability, and Chapter 6 briefly considers what is known about the effects of HIPAA on high-risk pools. Finally, we present results from our descriptive and multivariate quantitative analyses in Chapter 7. These analyses seek to quantify some of the relationships and issues identified in the preceding chapters, particularly those related to high-risk pool financing, affordability, and potential for growth.

2. Background on the Project and Data Gathering Methods

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes a federal role in the regulation of health insurance markets. It guarantees the availability of insurance to small employers and qualifying individuals who have had continuous coverage for 18 months and who have exhausted other sources of coverage, including COBRA. States may ensure availability by requiring private insurers to guarantee issue, and subsequent renewal, to qualifying individuals or by an “acceptable alternative mechanism.” High-Risk pools are the most common alternative mechanism and are the subject of this project.

High-risk pools were in operation in 27 states in 2000.² These pools are designed to provide health insurance to individuals who cannot obtain insurance in the individual market due to medical conditions. In 22 of the 27 states, the high-risk pool also serves as the state HIPAA alternative mechanism. CMS’s role is to assure that these high-risk pools meet statutory requirements but also that they are truly acceptable alternative mechanisms, responsive to the spirit as well as the letter of HIPAA. The purpose of the Evaluation of High-Risk Pools is to provide the information and analysis necessary to support CMS as it develops guidelines regarding the acceptability of high-risk pools.

Abt Associates has combined a comprehensive review and quantitative analysis of the characteristics of all pools across the United States with in-depth qualitative studies of individual state pools selected to highlight potential HIPAA effects as well as key issues affecting pool sustainability. This report reviews these tasks, identifies themes and trends, describes quantitative analysis conducted during this project, and provides in-depth review of specific state pools with interesting or noteworthy histories.

The remainder of this chapter reviews the major sources of data gathered under this project. The primary sources are: the NASCHIP annual meeting, networking interviews, Communicating for Agriculture’s annual data book, the Current Population Survey, laws gathered from the states, and other reports and materials.

2.1. NASCHIP Meeting

Three members of the Project Team—Steve Pizer, Juli Bradsher³ and JoAnn Volk—attended the 2000 Conference of the National Association of State Comprehensive Health Insurance Plans (NASCHIP), held October 25 through 27, 2000 in New Orleans. The conference provided an opportunity formally to introduce the Project Team to the NASCHIP members and to discuss the goals and scope of the Evaluation of High-Risk Pools. Leah Barron, the newly elected NASCHIP chair, introduced the Abt staff at the start of the conference. In addition, Steve Pizer, Abt’s Principal Investigator, made a brief presentation about the timeframe and general scope of work for the project, including the phone interviews that would occur in the weeks following the conference.

² Throughout this document we do not consider high-risk pools that began operation after 2000 (as of this writing, there are two states with new pools: Kentucky and Idaho).

³ Juli Bradsher subsequently left Abt Associates Inc. and is no longer a member of the Project Team.

The conference was a valuable opportunity for Abt staff to meet one-on-one with representatives of 15 of the 27 operating high-risk pools, to collect information about the pools, and to learn, through conference presentations and breakout sessions, about some of the issues related to designing and administering a high-risk pool as well as the current issues of most concern to high-risk pool board members and staff.

In the session entitled “Legal Issues for State Risk Pools,” pool administrators and staff shared emerging legal concerns and their strategies for addressing them. For example, one pool representative reported a recent increase in the number of cases in which a plan or employer goes out of business and fails to notify employees, so that an employee’s 63 days in which to pursue alternative coverage might lapse without the employee knowing it. In some cases, employers have continued to collect employees’ premium contributions after the coverage has been terminated. In response to such cases, Arkansas is considering including comprehensive health insurance plans in its statutes governing insurance fraud.

Other breakout sessions included:

- Risk Pool Start-up and Administrative Issues
- Assessing Stop-loss Insurers (discussed in Section 3.1.2)
- Disease Management/Case Management (discussed in Section 3.2.3)
- Risk Pool Low-Income Premium Subsidy Programs (discussed in Section 3.3.1)
- Latest developments in Risk Pools’ Use of the Internet (see Appendix D)
- Prescription Drug Cost Control (discussed in Section 3.2.2)
- Risk Pool Consumer Issues
- Risk Pool Board Member Responsibilities

The conference also included a roundtable discussion among the Executive Directors. The issues covered in that discussion included:

- How rapid enrollment growth can affect assessments: In Texas, assessments are growing exponentially as pool enrollment grows, so they may be approaching the limits of what the industry will accept.
- How premiums and loss ratios vary in states with separate pools for HIPAA eligible and traditional enrollees: Some states charge different premiums for the two groups of eligibles. Also, states have different experiences with the costs associated with the different groups of eligibles. For example, in Oregon, the loss ratio for HIPAA eligible enrollees is less than that for traditional enrollees. The opposite is true in Mississippi, where HIPAA eligible enrollees are more costly.
- How state rules differ regarding coverage for organ transplants: Some states provide coverage for “on the table” care but limit the benefit. More common is state coverage for aftercare, including prescription drugs.
- How states allow enrollees to change plans: State rules on this vary. Some states allow enrollees to move to a plan with a higher deductible, although some allow it only in certain circumstances, such as when there has been a rate increase. Other states allow enrollees to change plans only during the open enrollment period.

Overall, Project Team attendance at the NASCHIP meeting supplied exceptional background information used to frame questions and target interviews in the next phase of the project. Since this is an annual event, the NASCHIP meeting provides an invaluable opportunity for CMS to monitor developments among high-risk pools on an ongoing basis.

2.2. Networking Interviews

In order to have an in-depth understanding of the characteristics of and dynamics surrounding the implementation and sustainability of high-risk pools, we have conducted a series of networking telephone interviews in all of the states that currently have high-risk pools. Our initial networking interviews were completed with states' high-risk pool administrators, board members, and state officials who attended the NASCHIP meeting and with whom Abt staff met during the NASCHIP meeting. Although waiting to conduct these interviews until after the meeting has slowed our progress, the delay allowed us to establish rapport with prospective interviewees and identify information resources within each state, making our subsequent interviews more productive.

After the initial round, a second group of networking telephone interviews have been conducted with individuals involved in the implementation of high-risk pools but not contacted at NASCHIP. The interviews have been used primarily to: 1) identify information resources and key stakeholders available in each state, 2) discuss legislation or regulations that pertain to high-risk pools, and 3) learn about issues pertaining to funding, cost sharing, and access. The networking telephone interview guide used to structure the conversations is provided in Appendix C. Telephone discussions have ranged in length from about 45 minutes to as long as 2 hours. We have completed interviews with at least two individuals in each state.

2.3. Quantitative Database

To supplement and support the information gathered through interviews and documentation, the Project Team has developed a quantitative database. Information contained in the database has been used to study the uninsured and medically uninsurable, to chart state pool trends, and to estimate multivariate models describing the relationship between premiums and enrollments.

2.3.1. Communicating for Agriculture

Communicating for Agriculture's annual publication, *Comprehensive Health Insurance for High-Risk Individuals*,⁴ has provided most of the data used to assemble our project database. This publication is produced annually by the Communicating for Agriculture (C for A) lobbying group in cooperation with the National Association of State Comprehensive Health Insurance Plans (NASCHIP). Abt Associates obtained copies of the 1995-2000 editions of this guide (each of which contains a mixture of current and historical data). Information gathered by C for A is primarily provided by the high-risk pool for each state.

The Project Team transferred information from C for A into an electronic database by manual data entry. Information captured includes operational statistics for high-risk pools (e.g., enrollment,

⁴ *Comprehensive Health Insurance for High-Risk Individuals*, Fourteenth Edition, 2000, Communicating for Agriculture Inc., Fergus Falls MN.

premiums collected by the plan, and incurred claims), eligibility criteria (e.g., HIPAA eligibility, medical eligibility, and waiting periods), benefits (e.g., preventative care, transplant coverage, and pharmacy benefits), cost sharing (e.g., deductible levels), funding mechanism, types of plans offered (e.g., HMO, PPO, and indemnity), and premiums.

2.3.2. Current Population Survey

Data from the March release (years 1995-2000) of the Current Population Survey (CPS) have supplemented our C for A data. They allow us to estimate pool enrollment as a percentage of population or to evaluate premiums in light of income. The CPS is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics and is the primary source of information on the labor force characteristics of the U.S. population. The sample is scientifically selected to represent the civilian noninstitutional population. The CPS has been used by policymakers, academic researchers, and others to produce estimates on employment, unemployment, earnings, hours of work, and other indicators. The CPS contains a variety of demographic characteristics including sex, age, and race, as well as data on income, previous work experience, health, employee benefits, occupation, and industry.

For this project CPS data have been used for a state-level study of the uninsured. For the purposes of estimating statistics relevant to the uninsured, high-risk pools, or HIPAA, the CPS offers several advantages:

- By pooling several years worth of data, sample sizes are large enough to produce accurate state-level estimates;
- Data are released relatively quickly (data through 2000 are already available);
- The data are organized in a relatively easy-to-use format that requires minimal cleaning, linking, or other pre-preprocessing;
- The CPS asks a set of detailed questions regarding income and labor participation/employment;
- The CPS provides fairly comprehensive (though not ideal) health insurance information; and
- Some health status information is included.

The Project Team linked state-level aggregates computed from the March CPS data to the C for A data to create a rich database of information suitable for describing the uninsured population in both pool and non-pool states and for estimating multivariate models.

2.3.3. Demographic Control Variables

Both the cost and utilization of health services vary geographically. For example, the cost of a routine physician visit is likely to be higher in Connecticut than in Iowa. When conducting multivariate analysis, it is important to control for this type of variation. One potential proxy for both cost and use is per capita income; the cost of care is likely to be higher where incomes are higher. We have obtained current and historical per capita income information from the Bureau of Economic

Analysis⁵ and coded it into our dataset. We have also included Medicare payments per Medicare beneficiary as a second proxy for cost and use.⁶

2.3.4. Private Market Data

High-risk pools operate within a broader health insurance marketplace that includes, most importantly, other private, individually purchased plans. The state of the individual, or non-group, market—reflected by premium prices, and recent plan withdrawals—is likely to have a measurable impact on the state of high-risk pools—number of enrollees, losses, etc. The Project Team had hoped to collect information, by state, on non-group premiums, number of enrollees, and recent plan withdrawals.

This information has proven difficult to obtain. The Project Team has conducted a broad search for these state data. We have contacted the A.M. Best company, which gathers and publishes insurance industry data, and the National Association of Insurance Commissioners (NAIC). Both provide data on non-group premiums but neither reports on the number of enrollees or on withdrawals. We have also contacted actuaries who work at insurance consulting firms (Tillinghast, Milliman and Robertson, Deloitte and Touche), insurance companies (Blue Cross Association, Goldenrule), and other insurance-related groups (Health Insurance Association of America (HIAA), Federal Employees Health Benefits Plan (FEHBP)). All have told us that the information we seek is not available and would be costly to obtain. Indeed, many of them would also be interested in this information and have been unable to obtain it. In light of these difficulties, the Project Team suspended the search after consultation with the Project Officer.

2.4. State Laws

Differences in the operating experience of high-risk pools may be a product of the statutes and regulations that govern them. For example, premium and enrollment caps dictated by law have important implications for pool funding. We have collected and reviewed all state laws pertaining to high-risk pools. These laws reflect the particular circumstances and constraints prevailing in each state and have provided valuable background for the study of each individual high-risk pool. We also examined state regulations reported by CMS to be related to HIPAA compliance. In our review we found Alabama is the only state where regulations substantially affect operation of the high-risk pool. See Appendix B for a summary created by the Project Team for use as a convenient reference.

2.5. Other Reports and Materials

To supplement the initial interviews and C for A books, we have collected existing reports that might contain useful data, whether generated by the pools or by other interested parties. During the networking interviews, we asked interviewees for annual reports, marketing/enrollment materials, and any special studies that have been conducted on the pools. In nearly all cases, interviewees have sent materials to Abt Associates for the purposes of this study.

⁵ U.S. Department Of Commerce—Economics And Statistics Administration, Bureau Of Economic Analysis—Regional Economic Information System, “State Annual Tables 1929 – 1999 for the States and regions of the nation” (<http://www.bea.doc.gov/bea/regional/spi/>).

⁶ U.S. Census Bureau, Statistical Abstract of the United States: 1999 (119th edition), Washington, D.C., 1999.

Another information source we have explored is plan web sites. Most plans have web sites. We have identified the URLs for these and have downloaded information from them. A listing of URLs for the existing high-risk pool web sites are listed in Appendix D.

Finally, we learned at the NASCHIP meeting of the existence of the NASCHIP repository, which is maintained by the administrator of the Louisiana Health Plan. The repository is a central location where all members can catalog and store pertinent information about their plans. It is an historical archive for reference by all members. They have given us permission to look at information in the repository. However, it is a self-monitored and self-maintained information source, and it is up to each state to maintain the accuracy and currency of the information in the repository. We have concluded that the most recent information is more easily obtained from our interviewees. Consequently, information from the NASCHIP repository is likely to be redundant or out-of-date.

3. Themes from the Interviews

We have interviewed at least two people in each of the states included in this study, and from these interviews several themes have been identified. This section discusses those themes and wherever possible offers examples and detailed information from our interviews. Although our goal is to identify themes across states, it should be emphasized that the experience of each high-risk pool depends critically on the particular personalities, institutions, and political climate in its state. High-risk pool directors consistently caution that optimal solutions for one state may not even work anywhere else. See Appendix A for a brief summary of the characteristics of each state high-risk pool and Chapter 5 for summaries selected to highlight issues of sustainability.

3.1. Funding Adequacy and Stability

By far the most salient issue for high-risk pools is the adequacy and stability of funding. High-risk pools typically finance less than 60 percent of their operating cost (claims plus administration cost) through premiums, with the balance financed through other means. These include assessments collected from insurers, state appropriations, and dedicated taxes (see the Legal Analysis table in Appendix B for a review of states' statutory requirements regarding funding). In almost every case, legal and political obstacles must be overcome to secure funding and to maintain it from year to year. The primary legal obstacle to high-risk pool funding arises from the Employee Retirement Income Security Act of 1974 (ERISA). Because ERISA concerns are fundamental to every funding option, this section begins with a brief review of the provisions of ERISA that are relevant to high-risk pools. Following that, we discuss insurer assessments, then less common funding mechanisms. Appendix E provides a summary table of funding arrangements for each high-risk pool that accompanies the discussion in this section.

3.1.1. ERISA Issues⁷

Although ERISA was enacted primarily to address pension plans, it also applies to other types of employer-sponsored benefits. In effect, ERISA preempts any state laws that “relate to any employee benefit plan,” including health insurance coverage. This broad preemption includes one significant exception for states *regulating* insurance, but ERISA also prohibits states from considering employer-sponsored plans to be insurers. The result is that states cannot directly regulate employer-sponsored plans but can regulate insurers issuing policies to those plans.

Court challenges to state insurance laws have narrowed the application of ERISA, and it is clear that states have several options within ERISA for financing high-risk pools. In general, while states cannot tax employer-sponsored plans directly, they can impose taxes that may affect those plans. For example, generally applicable provider taxes have been found to withstand ERISA challenges, although many states consider such taxes politically difficult to impose.

⁷ This ERISA subsection draws heavily on “ERISA Complicates State Efforts to Improve Access to Individual Insurance for the Medically High-Risk,” by Pat Butler, a State Coverage Initiatives Issue Brief published by the Robert Wood Johnson Foundation (August, 2000) and available from www.statecoverage.org.

States can also impose general revenue taxes, or general business taxes on organizations, including taxes on third party administrators that do business with self-insured plans (as long as they are not treated differently from other service providers).

Taxes or assessments on traditional insurers are the most common high-risk pool funding mechanism used by states and are clearly allowable within ERISA. However, as the base of traditional health plans has declined, states have attempted to expand their base of taxable insurers. Some states include in this taxable base “stop-loss” insurers that provide insurance to self-insured employer-sponsored plans. While the scope of state jurisdiction in this area is not clearly defined, the *Travelers Insurance* decision (1995)⁸ makes clear that ERISA does not preempt state taxes on stop-loss insurers solely on the basis of the cost of such taxes to the self-insured plans they protect.

While some legal analysts⁹ believe that states can be more ambitious in assessing stop-loss insurers, legal uncertainties associated with ERISA have attenuated states’ aggressiveness in this direction.

3.1.2. Assessments

The most common funding mechanism for high-risk pools is assessments collected from insurers. This is one of the approaches outlined in the National Association of Insurance Commissioners (NAIC) model legislation and has been adopted in some form by 24 of 27 states currently operating high-risk pools.

In general, under an assessment mechanism the pool director periodically calculates the expected amount required to finance the pool deficit in the next period, then allocates that amount to each health insurer doing business in the state according to its share of the private health insurance market. As mentioned above, because of ERISA preemption, self-insured groups are exempt from these assessments.

This exemption creates instability in funding for the pools because as assessments grow to meet demand for pool coverage, private insurance rates must increase to fund the assessments. As private insurance rates increase, employers have a larger incentive to self-insure, thus escaping assessments and pushing rates higher for the remaining privately insured population. Recognizing this problem, private insurers, through their representatives on pool boards and before state legislatures, generally advocate to minimize enrollment in assessment-funded high-risk pools. Or, they promote alternative, more broadly based sources of funds.

Premium tax credits

One way to broaden the base of an assessment-funded high-risk pool is to allow insurers to offset some or all of their assessment payments with credits against their state premium tax liabilities. In effect, this arrangement provides state revenue to finance pool deficits and is therefore very broadly based. In fact, some of the states we interviewed said tapping into state revenue in this way is the most desirable form of financing because it provides the broadest possible funding mechanism.

⁸ *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995).

⁹ In particular, Pat Butler. See her paper “ERISA Complicates State Efforts to Improve Access to Individual Insurance for the Medically High-Risk,” a State Coverage Initiatives Issue Brief published by the Robert Wood Johnson Foundation (August, 2000) and available from www.statecoverage.org.

At least ten states provide an offset for insurers that are assessed. Of these, six states allow an offset for the full amount of the assessment, while four limit the offset, either as a percent of the assessment paid or through a cap on state revenue available for the offset. For example, in South Carolina, the assessment is approaching the cap of \$5 million. The assessment was \$4.5 million in 2000 and again this year. If the assessment exceeds \$5 million, the board must raise premiums to meet the excess costs.

As might be expected, premium tax credits are popular among insurers and less popular with legislators, since the funds committed to a premium tax credit are not available for other purposes. In Florida, the repeal of a premium tax credit led to loss of political support from the insurance industry, resulting in the closure of the high-risk pool to new applicants in 1991. By contrast, the Minnesota high-risk pool survived the repeal of a premium tax credit in 1987 and operated without an alternative public subsidy until 1993.

A different problem with premium tax credits is illustrated by Arkansas. In this case, the high-risk pool has recently grown to the point where the largest assessed insurers are offsetting their entire premium tax liabilities. As a result, there have been discussions at the Department of Insurance to fund the pool directly from state revenue. However, because of state budget constraints, the board does not plan to formally request such funding this year, but will request a study of the issue for legislative consideration in 2003 (the Arkansas Legislature meets every two years). Until then, the board may ask the legislature to decrease plan benefits and raise premiums in order to finance rapidly-growing enrollment.

Stop-loss assessment

To broaden the funding base of assessment-funded high-risk pools, some states (prominently Oregon) include stop-loss insurers in their assessments. This innovation has great potential to stabilize pool funding, and it therefore attracted substantial interest among pools and state legislators at the NASCHIP conference. This interest is tempered, however, because of legal uncertainty. A district court in Oregon has upheld stop-loss assessment against an ERISA-based challenge,¹⁰ but it is unknown how other or higher courts might rule.

The term “stop-loss insurer” typically refers to an insurer that issues policies covering losses over a threshold amount, incurred by individuals enrolled in self-insured health plans. This insurance is issued to the self-insured plan. If the threshold is relatively high, premiums are relatively low.

Assessing stop-loss insurers appeals to states because it is a way to gain funding from self-insured plans that are exempt from a direct assessment because of ERISA. In many states, self-insured plans comprise a significant portion of the health insurance market (by some estimates, more than half the market). Since catastrophic losses incurred by small numbers of individuals could threaten the solvency of a self-insured plan, stop-loss coverage is very common. Including stop-loss insurers in an assessment can significantly broaden the funding base.

¹⁰ *Safeco Life Ins. Co. v. Oregon Medical Insurance Pool*, Civ. No. 920331-MA and 92-512-MA, D. Ore. Sept. 1, 1992.

In *Safeco Life Ins. Co. v. Oregon Medical Insurance Pool*,¹¹ the Oregon high-risk pool successfully argued that stop-loss insurance is subject to state regulation under ERISA, allowing the pool to establish an assessment. Because stop-loss premiums are relatively low, the Oregon pool decided to establish per capita as opposed to premium volume assessments, collecting the same amount per insured from stop-loss and traditional insurers. This mechanism spreads the burden as evenly as possible between self-insured and commercially insured plans despite the fact that stop-loss premiums are lower. However, this per capita method is not common across the states.

Of the ten states that include stop-loss insurers in their assessment base, seven apportion the assessment based on an insurer's premium volume: Illinois, Minnesota, Texas, Kansas, Missouri, Alaska and Arkansas. Because stop-loss premiums are relatively low, stop-loss insurers would be responsible for a relatively smaller assessment if it is based on premium volume rather than the number of lives covered. For this reason, stop-loss insurers may be less likely to challenge an assessment if it is based on premium volume. Furthermore, allowing a tax offset may also make an assessment less vulnerable to a legal challenge. In Arkansas, Missouri and Minnesota, assessments are completely offset by premium tax credits, and in Kansas 60 percent of an insurer's assessment can be offset.

Just three states use a per capita basis for their assessment (including Oregon). Mississippi relies on an "honor system" that asks stop-loss insurers to self-report the number of lives covered by its plans (although they are currently working on a survey process to obtain that information). As a result of legislation enacted in March 2000, Washington state will assess stop-loss insurers on a per capita basis but at one-tenth the rate of other assessed insurers.

3.1.3. Premium Levels

Along with assessments, premiums are the other primary source of funding for high-risk pools. The statutes establishing the pools cap premiums at some level in proportion to the average premium prevailing in the private non-group market. The NAIC model legislation recommends premiums be no lower than 125 percent to 150 percent, and not higher than 200 percent of prevailing market rates. In practice, the most common level is 150 percent (see the Legal Analysis table in Appendix B for a review of states' statutory requirements regarding premium levels). Nearly every state bases its premium cap on some standard developed from the non-group market, using either an average of the entire non-group market or just the largest carriers in that market. For example, as a result of legislation enacted in March 2000, Washington state will change the basis for its standard rate from the small group market to the non-group market. Since group policies generally have lower premiums, using the small group market in the base for the pool premium cap tends to reduce the cap.

Although the premium cap often determines pool premium rates, ten states have chosen to maintain premiums below their mandated caps. This is done primarily to facilitate access to the pool, but also may have the effect of mitigating adverse selection.

Adverse selection is the phenomenon whereby individuals who expect to incur high health care costs are more likely to buy insurance than those who expect to be healthy. When premiums increase, relatively healthy individuals are more likely to forego insurance, leaving relatively costly individuals

¹¹ Ibid.

maintaining their coverage. If adverse selection is severe enough, insurers who increase premiums to cover losses can experience growth in per enrollee losses instead.

3.1.4. Provider Taxes and Other Funding Sources

Beyond premiums and assessments, a variety of other funding sources have been employed by individual states. These include:

- Cigarette tax revenue in California,
- Provider taxes in Minnesota,
- Interest on unclaimed property funds in Colorado,
- Direct state appropriations in Louisiana, Utah, Illinois, and Wisconsin,
- Surplus funds from the Workers Compensation Assigned Risk Plan in Minnesota.

These funding sources provide additional resources and signal a commitment from the state to the high-risk pool. However they can lead to access problems if the funding mechanisms are unstable or uncertain. Revenue from a cigarette tax can fluctuate and decline, provider taxes have proven to be politically difficult to impose and maintain (the Minnesota pool no longer receives these revenues), and direct appropriations require annual legislative review and action.

This uncertainty can affect enrollment. If enrollment grows, additional funds may be required, crowding out other public spending or forcing a tax increase. Since legislators generally wish to avoid these outcomes, they may be tempted to limit or reverse enrollment growth in the high-risk pool, potentially endangering compliance with HIPAA.

Two states illustrate the difficulty of trying to fund a pool without an assessment mechanism. Colorado began operating a pool in 1991 with a direct appropriation from the state. Ultimately, this funding source was replaced with funding from the state's unclaimed property account. However, these assets can be claimed at any time by the entities to which they are owed, so legislation was passed to use only the interest on the assets. With this change, pool funding dropped drastically from more than \$4 million to just \$1 million. In Louisiana, the non-HIPAA pool has struggled with uncertain funding from the state and from a service charge on hospital procedures. The pool is closed to new enrollment. While the HIPAA pool has remained open to enrollment, pool staff have tried unsuccessfully to expand the assessment base, including an effort to assess bail bonds.

California is another state that does not rely on assessments to fund its high-risk pool. Instead, the California pool is funded primarily by premiums and a limited stream of revenue from the Cigarette and Tobacco Surtax Fund (\$40 million per year since 1997). To avoid shortfalls, enrollment in the California pool is capped (at 19,815 in 2000, but expected to drop to 15,000 in 2001) and the waiting list has grown to 4,000, each expected to have to wait about one year.

3.2. Cost-containment Efforts

One way to minimize pool deficits and the funding challenges that accompany them is to contain claim costs. High-risk pools are increasingly implementing managed care, pharmacy benefit management, and disease management as cost-containment strategies. Some states, like Florida and California, are more aggressively using managed care techniques to control costs. Smaller, more

rural states like Oklahoma, Alaska, and Utah—which have fewer managed care options available—tend to have implemented some managed care options, but are less likely to have pharmacy benefit managers or formal disease management programs.

3.2.1. Managed Care

Preferred provider organizations (PPOs) are the most common form of managed care provided through high-risk pools. Twenty states contract with PPOs, six states contract with health maintenance organizations (HMOs), and six states are not contracting with either PPOs or HMOs. The use of managed care is particularly pronounced in large states with significant urban populations like California, Texas, and Florida, all of which have elaborate contracts with managed care networks and pharmacy benefit managers (more on pharmacy benefit management in the next section).

Pools may gain access to existing PPO networks of physicians and hospitals by paying a per-enrollee access fee or as part of an agreement with a third party administrator. In addition, high-risk pools in states with substantial managed care penetration of the private market, like California, may be able to offer more choice by contracting with more than one managed care organization in each part of the state.

States that offer multiple managed care options to their enrollees typically provide incentives to encourage the selection of the least costly alternative. For example, Florida encourages managed care techniques by providing 90 percent reimbursement for individuals under case management and 80 percent reimbursement for individuals utilizing a PPO. Individuals who use neither are reimbursed at 60 percent for the first \$10,000 and 70 percent thereafter.

3.2.2. Pharmacy Benefit Management

Not all high-risk pools offer pharmacy benefits, but among those that do, growth in pharmacy benefit costs poses a significant cost-containment challenge. Pharmacy benefit managers (PBMs) offer pools access to sophisticated claims handling, including tiered co-payments, discounts from manufacturers, and advanced utilization tracking capabilities that can complement disease management programs as well as help target future negotiations between the pool and the PBM.

At least six states are currently using PBMs (Indiana, Nebraska, North Dakota, Texas, South Carolina and Kansas) and another three, while not using formal PBMs, are using pharmacy cost containment measures like managing prescription use or contracting with pharmacy networks for a discount (Oklahoma, Washington and Florida). At least three states are actively considering contracting with a PBM (Mississippi and Connecticut) or providing tiered co-payments (Colorado).

3.2.3. Disease Management

The term “disease management” refers to a constellation of programs designed to contain health insurance costs by encouraging best practices, preventive care, and regular monitoring of chronically ill individuals. The most common disease management programs include:

- Asthma,
- Cardiology,
- Cancer,

- Diabetes,
- End stage renal disease,
- Maternal/neonatal care.

These programs are growing in popularity among private insurers generally, but are still in the early stages of development among high-risk pools. High-risk pools can contract with disease management companies directly or through their third party administrator, or they might benefit from disease management programs already implemented by managed care providers.

Seven states currently use disease management, most notably for diabetes, prenatal care, heart disease and asthma (California, Montana, North Dakota, South Carolina, Iowa, Florida and Missouri). We learned in our interviews that seven more states are considering disease management (Alabama, Illinois, Indiana, Minnesota, Wyoming, Utah, and Mississippi).

Although most high-risk pools do not yet employ formal disease management programs, nearly all pools engage in some level of case management, keeping in touch with their most costly enrollees and attempting to encourage cost-effective care. Some states are more aggressive in case management, as Connecticut is for mental health and substance abuse benefits. Others are less aggressive. For example, Oklahoma uses case management primarily to allow cost-effective exceptions to coverage limits.

3.3. Access Issues

The principal use of high-risk pools is to cover individuals who have been deemed uninsurable by insurance carriers. Beyond this, high-risk pools provide access to health insurance to some of those who otherwise would not have insurance for other reasons (for example they are self-employed, unemployed, or live in an area with no private, non-group insurers). However, through our networking interviews, we have identified a number of factors that can affect the level of that access. These dimensions are: cost of coverage, including premium and deductible levels; waiting lists; marketing and outreach efforts; and the degree to which consumers are represented on the boards of the high-risk pools. These topics are addressed in Sections 3.3.1 through 3.3.3.

After completing our networking interviews, we conducted a supplementary analysis of the high-risk pool application process to determine if we could identify any aspects of the process that might have a substantial effect on access. This analysis is discussed in Section 3.3.4.

3.3.1. Cost of Coverage

Premium Levels

Premium levels have a significant effect on access. Premium levels in most states are limited by statute and by decision-makers' concerns about the practical affordability of coverage. States vary in their premium caps but the most common percentages are between 150 percent and 200 percent of the average non-group premium among insurance carriers in the state. However, as a means of keeping high-risk insurance affordable, some states have capped premiums at levels as low as 125 percent (Minnesota, Oregon, and Wyoming). By contrast, Florida has a cap of 250 percent.

In general, many states have attempted to keep premium levels at the 125-150 percent range in order to promote affordability. Mississippi has tried to keep its premiums near the minimum premium allowed by law, and Alaska has intentionally let its premiums drop from 175 percent to 150 percent, well below its cap of 200 percent. In an effort to increase enrollment in Missouri, the pool board has frozen rates for the last two years, so that the premium as a percent of the standard market rate has dropped slightly.

Some states offer different premium levels for different enrollees. For example, Washington has a lower premium cap for managed care enrollees and Montana has a lower premium cap for HIPAA-eligible enrollees. The Florida pool started with a premium cap of 150 percent, but when the pool was closed to new enrollment in 1990, the statute was also changed to increase premiums to between 200 and 250 percent (allowing some variation on the basis of individual risk).

Deductible Levels

One of the access issues raised in some interviews with states was the role that deductible levels play in improving access to health insurance for some people who would otherwise not be able to afford it. In Alaska, for example, pool staff believe that very high deductible levels (\$5,000 and \$10,000) significantly increase access by permitting a steep reduction in premiums. In fact, in Alaska, the \$5,000 deductible option has the highest enrollment among the six deductible options they offer.

Most pools offer between two and six deductible levels. The lowest deductibles are typically between \$200 and \$1,000 and the highest deductibles are typically between \$1,000 and \$2,000. Three pools offer deductibles as high as \$10,000 (Arkansas, Florida, and Alaska).

Nine pools have changed their deductibles in recent years.¹² For example, in response to HIPAA's requirement to offer consumers choices, Kansas expanded from two plans with deductibles of \$1,000 and \$5,000 to five plans with deductibles ranging from \$500 to \$5,000. As another example, Mississippi recently raised the deductibles for new enrollees in its two plans to \$1,000 and \$2,000. The plan's actuary said the previous deductible levels of \$500 and \$1,500 were under-priced. The other states making deductible changes were California, Illinois, New Mexico, Texas, and Wisconsin.

Low-Income Subsidy Programs

Although capping premiums makes high-risk pool coverage more affordable, the cost is still too high for many of the people the pools are designed to serve. In response to this problem, several states have adopted premium subsidy programs to help low-income individuals afford pool coverage.

The states that currently offer low-income subsidy programs for high-risk pool enrollees are Colorado, Connecticut, New Mexico, Oregon, and Wisconsin. All five offer reduced premiums for people that qualify based on income; only Connecticut and Wisconsin offer both reduced premiums and reduced deductibles. Connecticut and Colorado have set reduced premiums for qualifying individuals, while Wisconsin, New Mexico and Oregon offer sliding-scale subsidies based on income. Additional program details are as follows:

¹² In most cases, we have deductible information only as far back as 1995, the earliest Communicating for Agriculture volume available to us.

- Connecticut: The Special Health Care Plan (SHCP), for individuals with incomes up to 200 percent of the federal poverty level (FPL), offers enrollees a discounted premium set at 80 percent of the standard rate. Enrollees may also qualify for a reduced deductible (reduced from \$500 to \$200 for individual coverage and from \$1000 to \$400 for family coverage). One half of the total pool enrollment comes from SHCP, and the program is funded through a combination of reduced reimbursement rates for providers and an assessment on insurers.
- Wisconsin: The program provides a sliding-scale subsidy for premiums for individuals with annual incomes up to \$25,000 (individuals pay 130 percent of the standard rate if their income is between \$10,000 and \$25,000 or 100 percent of the standard rate if their income is \$10,000 or less). Individuals with annual income of up to \$20,000 also qualify for reduced deductibles. The regular \$1000 deductible is reduced on a sliding scale to \$500 for incomes up to \$10,000. The program has been used by about 35 percent of the pool membership, and is funded in part by a state appropriation (\$1.56 million for the 1999/2001 biennium), with the balance funded from assessments and adjustments to provider payments.
- New Mexico: Individuals qualify for discounted premiums on a sliding scale basis, with the discount ranging from 25 to 5 percent for incomes between 100 and 200 percent FPL. Seventeen percent of the pool enrollees receive a subsidy.
- Colorado: Individuals with annual incomes up to \$30,000 and living in rural areas outside the Denver-Boulder area qualify for a 20 percent reduction in the pool premium. The discount is intended to equalize the rates for PPO coverage in rural areas with the cost of managed care coverage available only in the metropolitan Denver area.
- Oregon: The state coordinates its health insurance subsidy program, the Family Health Insurance Assistance program (FHIAP) with its high-risk pool the Oregon Medical Insurance Pool (OMIP), so that qualifying individuals can apply the subsidy toward the purchase of coverage through the pool. FHIAP provides a sliding scale of subsidies to individuals with incomes up to 170 percent FPL. FHIAP pays between 75 and 95 percent of the cost of coverage. Program participants must enroll in their employer's plan if the employer makes a contribution toward the premium. Otherwise, enrollees apply the subsidy toward the purchase of individual coverage or OMIP coverage if a commercial insurer denies them coverage. To be eligible for FHIAP, though, individuals must be uninsured for six months prior to applying for the subsidy. Therefore, HIPAA-qualified individuals who obtain OMIP coverage would not qualify for the subsidy unless they were already receiving the subsidy for employer-sponsored coverage. If an individual loses this subsidized group coverage, then his or her FHIAP subsidy could be applied toward coverage in the pool.

In addition to these well-established programs, there are several noteworthy special cases discussed below.

In March 2000, Washington state enacted a comprehensive health reform bill that includes a program to reduce premiums for 50- to 64-year-olds enrolled in the Washington State Health Insurance Plan. Individuals with incomes up to 300 percent of the FPL may qualify for a reduced rate for high-risk pool coverage. To fund these discounts, the state appropriated \$200,000 for the biennium, so the pool staff do not expect to be able to cover many individuals. The state is currently developing an

application process for the discount, which will be administered by a separate state agency with experience in means-tested programs.

In our interviews, we found several states had either considered a subsidy program in the past, or are considering one for the future. Louisiana and Alaska considered a subsidy in the past, and Minnesota, Montana, and Utah are currently considering subsidy arrangements. Of these states, Minnesota is the only one in the process of developing a plan to present to the legislature; however, this issue is one of the top priorities in the strategic plan Utah is currently developing.

While a number of states said subsidizing coverage for low-income individuals would be beneficial, funding is clearly a substantial hurdle. In Illinois, the Legislature has authorized a subsidy program but has never allocated the necessary funding. In Oregon, FHIAP has a waiting list of 14,000, some of whom would probably qualify for coverage in the high-risk pool. And in Mississippi, state law prohibits the use of federal or state funds to cover the cost of pool coverage, so a subsidy program does not appear to be possible under current law.

Oklahoma does not have a subsidy program as defined here, but the pool reports that some enrollees have their premiums covered by the Cystic Fibrosis Society and there has been interest in the state Department of Health to pay the premiums of people with HIV/AIDS. It is not clear to what extent an enrollee's income is or would be considered in these programs.

3.3.2. Waiting Lists

Waiting lists have raised an interesting and often difficult concern in some states. The advantage of waiting lists is that they provide a fail-safe means of cost control. The problems created for access, however, are obvious. For example, in Illinois, the non-HIPAA-eligible pool is currently closed for enrollment, but the HIPAA pool is open to new enrollment. The same is true in Louisiana, where the non-HIPAA-eligible pool has a waiting list but the HIPAA pool will "take all comers." According to Louisiana pool staff, it is difficult to explain to potential applicants the differences between individuals who are eligible under HIPAA and those who are eligible for the non-federal pool but who must go on a waiting list rather than become immediately insurable once eligibility is confirmed.

By law, no state has a waiting list for its HIPAA-eligible applicants. Additionally, most states do not have waiting lists for non-HIPAA-eligible applicants, but many states have statutes that authorize pools to institute a waiting list if financial risk becomes too great. For example, if Colorado does not get the assessment that is currently being considered by the Legislature, it probably will have to close the pool to new enrollment.

Other states limit their enrollment according to available funds. In Mississippi, the pool actuary estimates the number of enrollees that can be accommodated with available funding (currently estimated at 2,800-3,000 enrollees, with actual enrollment at about 2,500). If the actuary advises the board that enrollment is approaching the maximum number of enrollees, the pool would institute a waiting list for non-HIPAA enrollees. Similarly, California's high-risk pool revenue is expected to cover only 15,000 people in 2001 (19,815 were enrolled in 2000). Florida's pool (non-HIPAA), on the other hand, is a special case because it is closed to new enrollment and does not maintain a waiting list. As of this writing, the Florida Legislature is considering a plan to reopen the pool.

3.3.3. Board Composition

Although not always the case, board composition can be an indication of the level of consumer input and involvement in high-risk pools. Some states allocate seats to individuals who either are eligible for the pool themselves or have a child who is eligible. In Alaska, for example, the risk pool started through a consumer's interest and awareness campaign. The consumer, who had been denied insurance coverage because of health problems, conducted research and found the NAIC model legislation. He presented the model legislation to an Alaska legislator and pushed to have it presented and passed by the Alaska Legislature.

The NAIC model legislation recommends that the insurance industry not have a majority of the seats on a board. However, many boards are dominated by industry, including the board in Alaska, which has two consumer representatives and five industry representatives. Of the 27 pools included in this study, 10 have an industry majority, 12 do not, and four are ambiguous in their composition.¹³ (See the Legal Analysis table in Appendix B for a review of states' statutory requirements regarding board composition). Connecticut's board is made up entirely of industry representatives. The only requirement regarding board composition is how the seats are apportioned within the industry, for example, two positions for Blue Cross/Blue Shield and heavy HMO representation.

Even when consumer representation is specified in law, however, consumer input and involvement is not assured. In South Carolina, three positions out of eight are designated for consumer representatives. However, as the first consumer appointments left the board, successive Governors failed to appoint replacements. As a result, the board has not had a consumer representative since March 1998. The current Governor plans to make those appointments soon.

3.3.4. The High-Risk Pool Application Process

The literature on "take up rates" in public programs has shown that complex eligibility rules and application procedures, as well as burdensome documentation requirements, prevent individuals from applying for programs for which they would qualify. A national survey of low-income parents identified several barriers: complex eligibility rules, a complicated enrollment process and application, and unnecessary verification requirements.¹⁴ These burdens were shown to affect program enrollment. Eligible families either didn't think they would qualify or they were discouraged by the enrollment process. The same barriers can affect pool enrollment. Complex eligibility rules, lengthy paperwork, and burdensome documentation requirements can diminish access to pools.

In this section we begin to evaluate whether barriers to access to high-risk pools exist in the application process or marketing practices of existing pools. First, we explore in greater detail effective strategies for reaching potential enrollees. Next, we consider ways that the pool application processes could be improved to increase access and encourage enrollment. To gather information for this section, we examined the application materials for each currently operating pool, and we

¹³ Board composition is ambiguous in some states because appointments to the board are made by the governor, insurance commissioner, or the legislature, and there is little or no statutory guidance as to who may be selected.

¹⁴ Perry, Michael, Susan Kannel, R. Burciaga Valdez, and Christina Chang, "Medicaid and Children: Overcoming Barriers to Enrollment; Findings from a National Survey," Henry J. Kaiser Family Foundation, January 2000.

conducted additional interviews with the consumer representatives on two pool Boards of Directors (Alaska and New Mexico) and pool staff involved in outreach and enrollment in four states (Minnesota, Illinois, Connecticut, and Texas).

By focusing on application and marketing procedures we do not intend to dismiss the question of affordability. Indeed, as has already been discussed, pool premium levels are probably the single most important determinant of enrollment. With information on premiums made available early in most application processes (whether on-line or by phone), most applicants decide early in the process if they can afford the premiums. Based on our interviews, few individuals begin the process and drop out later because they decide the coverage is unaffordable. What we do not know is how many individuals never even begin the application process because they consider the premiums to be too costly. For those who decide to apply for high-risk pool coverage, enrollment in a pool can be encouraged through simplified application features and procedures. Many, if not most, applicants need assistance in completing an application, whether from an agent or pool enrollment staff. The next section provides details on how high-risk pools work with insurance agents.

Reaching Applicants

Most high-risk pools rely on agents as their primary mechanism for reaching potential enrollees. For example, Illinois receives 60 percent of its HIPAA enrollees and 45 percent of its non-HIPAA pool enrollees through agents. Arkansas reports that 63 percent of its applications were received through an agent.

Some states are more formal in their outreach to agents. In Wyoming, for example, agent awareness is promoted through the state licensing test. The test for agents includes questions about the risk pool. In Oklahoma, the Department of Insurance includes information about the high-risk pool in agents' continuing education materials. Its statute states that the pool must do some advertising (which may be fulfilled through work with agents).

State law and high-risk pool actions can encourage this flow of information from agents to potential enrollees. Insurers can provide uninsurables with information on a high-risk pool when they are rejected for non-group coverage. Some pools rely on carriers to do this voluntarily (for example, Texas, Connecticut and South Carolina), but others require the notice in law (Alaska, Kansas and Iowa). All states with high-risk pools could require this action by carriers and maximize the use of agents in getting information about the pool to uninsurables.

Other actions can maximize the role of agents in outreach to uninsurables. For example, state agent licensing and/or continuing education requirements can include information on the high-risk pool. Illinois includes information on its pool in its agent continuing education program because pool officials believe that to effectively represent the pool to potential enrollees, agents must have a base of knowledge on pool eligibility and benefits.

Another suggested way to encourage the role of agents is to provide them with information packets (including an application) that they can share with individuals who have been denied coverage. In Connecticut, agents have asked for a "cheat sheet" that summarizes the pool eligibility requirements, coverage options and premiums. The pool staff plan to produce such a summary sheet for the agents.

Other incentives may encourage the participation of agents in promoting the pool. Most states offer agents a fee, ranging from \$25 to \$100, paid when an applicant is enrolled. However, Connecticut's

Health Reinsurance Association pays agents upon referral because its primary goal is to encourage agents to immediately refer applicants so that HIPAA-eligibles do not miss their 63-day window in which to apply. Another potential incentive pools are using is to “pitch” the pool as an opportunity for agents to get business they might not otherwise have. Although an agent that refers an applicant to the pool will receive only a modest referral fee rather than regular commissions, they may be able to write other policies for that individual (i.e., property, life and auto coverage).

One potential downside of focusing outreach efforts on agents is that individuals who apply for coverage directly and without an agent (i.e., through on-line insurance brokers or from direct writers) may “fall through the cracks” if information on the pool is primarily provided through agents. To address this concern, states are using a variety of other outreach strategies.

One such strategy is advertising. Illinois and Connecticut have established arrangements with local broadcasters to air Public Service Announcements (PSA). In Illinois, pool staff reported a rise in applications and calls for information in the month after a PSA has aired. When the New Mexico pool recently opened, enrollment far exceeded initial expectations. Pool officials credit a comprehensive advertising campaign that included print, radio and television media.

Another successful outreach activity is to do information presentations to target audiences, including the employees of large employers that are scheduled to close down and patient support groups (for example, a support group for organ transplant patients). Although some pool staff pursue this strategy aggressively (e.g., Alabama), one pool representative with whom we spoke said that such information presentations should only be done on request. To pro-actively seek out such opportunities would, in their view, conflict with their mission to be an insurer of last resort that is not in competition with commercial carriers.

Regardless of whether agents are the source of applicants, the design of the application process can affect the number of eligible individuals who ultimately enroll in high-risk pools. The next section discusses some relevant design features that we identified through interviews and our review of pool applications.

The Application Process

The pool application process should include clear eligibility guidelines, a simple application form, and personal assistance for applicants who need help completing the application. Several features reinforce these three main goals.

Making information available online, in combination with a toll-free phone number to call with questions, can make the process more easily understood. Most pools (19 of 27) have information available online regarding pool eligibility requirements, coverage and premiums, as well as an application form and contact information for the pool. In Texas, a rapidly-growing pool, enrollment staff estimate that 50 percent of pool applications are received through the pool web-page.

In general, the application process can be simplified by requiring only information that is necessary to determine eligibility. For example, since HIPAA-eligible applicants would not be subject to underwriting, no medical history is necessary. Some features that are considered helpful are:

- Including a checklist with the application form to help applicants know if an application is complete.

- Making eligibility requirements clear. Illinois posts a form that helps applicants clearly determine if they are HIPAA eligible or not (and therefore which form they must use to apply). Connecticut has a flow chart that helps applicants determine if they are eligible for the subsidy program.
- Providing a toll-free number for applicants to speak with enrollment staff for questions concerning eligibility and enrollment. In Illinois, pool staff estimate 75 percent of the applications require some staff attention to help applicants complete the application. Connecticut pool staff also report that applicants need personal involvement in order to remain in the application process.

Other application features can be significant hurdles for some applicants. For example, documentation requirements to prove an applicant has no other coverage option and to prove residency can be burdensome. Similarly, documentation is required to prove the period of employer-sponsored coverage or beginning and ending dates for COBRA coverage. For some applicants, this information can be difficult to obtain. Illinois staff will call employers to verify information (because they say it is “awkward for some people to call a former employer” for required information about coverage dates or offer of COBRA coverage). In addition, the Illinois pool will accept other forms of proof, including an initial COBRA election letter, employer verification of coverage end dates over the phone, and an insurance card that includes end-date information. These other forms of proof can be especially helpful if the applicant is trying to apply for pool coverage prior to his other coverage ending in order to ensure continuity of coverage. Documentation to prove an applicant is a resident of the state is a greater hurdle for non-HIPAA applicants who may have to prove residency for a period of time. HIPAA-eligible applicants need only be a resident on the day they apply for coverage.

Some other features that represent potential hurdles in an application process are: requiring a detailed medical history (with provider names, dates and diagnoses), requiring more than one notice of rejection from a carrier, and requiring two or more months’ premium payment with the application. A summary of high-risk pools’ application processes can be found in Table 3.1.

Table 3.1: Application Features

State	Web site	Application Online	No. of pages ¹⁵	Medical History	List of conditions ¹⁶	Proof of Residency	Prepay Premium	Documentation from Employer
Alabama	Yes	Yes	2	No	No	No	No	No
Alaska	Yes	Yes	3	No	Yes	No	Yes	No
Arkansas	No	N/A	2	No	No	Yes	No	No
California	Yes	Yes	4	No	No	No	Yes	No ¹⁷
Colorado	Yes	No	4	No	Yes	Yes	Yes	No
Connecticut	No	N/A	1 ¹⁸	No	No	No	Yes	No
Florida	Yes	N/A ¹⁹						
Illinois	Yes	Yes	5	No	Yes	Yes	No	Yes
Indiana	Yes	Yes	5	Yes ²⁰	Yes	Yes	Yes	No
Iowa	Yes	Yes	2	No	Yes	No	Yes	No
Kansas	Yes	Yes	5	Yes ²¹	No	Yes ²²	Yes	No
Louisiana	Yes	Yes	9	Yes	No	Yes	Yes	No

¹⁵ Not all pages necessarily apply to all applicants (for example, medically-eligible requirements, agent information, or bank draft information for automatic withdrawal of premiums)

¹⁶ Can be eligible based on list of health conditions (does not require documentation)

¹⁷ Documentation required if applying for deferred enrollment.

¹⁸ One page application, but seven different applications, depending on coverage.

¹⁹ Pool is not open for enrollment.

²⁰ For three months prior to application for purposes of Pre-Existing Condition Exclusion

²¹ For medically-eligible applicants only.

²² For non-HIPAA applicants only.

State	Web site	Application Online	No. of pages	Medical History	List of conditions ¹⁶	Proof of Residency	Prepay Premium	Documentation from Employer
Minnesota	Yes	No	6	No	Yes	No	Yes	No
Mississippi	Yes	No	6	No	Yes	No	Yes	No
Missouri	Yes	Yes	4	Yes	No	Yes ²³	No	Yes
Montana	No	N/A	3	No	Yes	Yes	No	No
Nebraska	No	N/A	2	No	Yes	No	Yes	No
New Mexico	Yes	No	1.5	No	No	No	No	No
North Dakota	Yes	No	2	No	No	No	Yes	No
Oklahoma	No	N/A	6	Yes	Yes	Yes	Yes	No
Oregon	Yes	No	4.5	No	No	Yes	Yes	No
South Carolina	No	N/A	2	Yes ²⁴	No	Yes	Yes	No
Texas	Yes	Yes	8 ²⁵	No	Yes	Yes	Yes	Yes
Utah	Yes	No	3	Yes ²⁶	No	No	No	No
Washington	Yes	Yes	3	No	No	Yes	Yes	No
Wisconsin	Yes	Yes	4	No	No	No	Yes	No
Wyoming	No	N/A	2	No	No	No	No	No

²³ Require two written proofs of residency.

²⁴ For six months prior to application for purposes of Pre-Existing Condition Exclusion

²⁵ Applicant's employer must submit a two-page form in addition

²⁶ Applicant must submit complete medical records.

Conclusion

Access to high-risk pools is primarily determined by premium levels, waiting lists, and eligibility rules, but marketing methods and application processes also play an important role. Through interviews with pool staff and consumer representatives, we learned several key lessons about the access implications of operational decisions made in these areas.

- **Agents are a key part of a pool’s outreach effort.** One pool official suggested that most people seeking coverage will go to a carrier because they don’t assume they will be denied coverage based on a health condition. This is supported by a recent study illustrating how even minor health conditions prevent individuals from getting full coverage in the non-group market.²⁷ Therefore, using agents as the main mechanism for reaching potential pool enrollees is a logical choice, and there are a number of ways to encourage their participation in promoting the pool. These include providing a referral fee and including information on the pool in agent licensing and/or continuing education requirements.
- **Keep the application process simple.** Literature on barriers to enrollment in public programs provide useful lessons for enrollment in high-risk pools. Complex eligibility rules, lengthy paperwork, and burdensome documentation requirements can diminish access to pools.
- **Applicants need personal attention.** Until recently the Illinois pool used its administrator for eligibility determinations and enrollment. However, they decided to bring those functions “in house.” In the view of pool staff, insurance carriers are accustomed to applying very different eligibility rules that include health underwriting. In contrast, pool staff felt their eligibility determinations require an entirely different approach – one that puts the burden on the pool staff and provides considerable personal attention. In order to expedite the process, Illinois pool staff will call rather than write an applicant if they have submitted an incomplete application, and they will accept other forms of proof in lieu of the documentation required by the application.
- **Even with agents involved, a simple application process, and personal assistance, access for HIPAA eligibles may be compromised.** Pool staff in Connecticut and Illinois noted that some applicants who would be eligible under the federal eligibility requirements must instead enroll in the non-HIPAA high-risk pool because they missed the 63-day window in which to apply for HIPAA coverage. The high-risk pool imposes a pre-existing condition exclusion that is not applied for HIPAA-eligible enrollees. In Illinois, pool staff estimate commercial carriers require a minimum of four to six weeks to complete the underwriting process, leaving HIPAA eligibles little time to apply to the high-risk pool. In response to this situation, legislation passed recently in both houses would extend the 63-day window to 90 days.

²⁷ Pollitz, Karen, Richard Sorian and Kathy Thomas, “How accessible is Individual Health Insurance for consumers in less-than-perfect health?” Henry J. Kaiser Family Foundation, June 2001.

4. High-Risk Pools and State-financed Health Insurance

Both high-risk pools and Medicaid are programs that provide health insurance for individuals who would most likely otherwise be uninsured. Both programs are administered at the state level, so, in principle, there may be coordination issues between them. This chapter attempts to identify what some of those issues may be, and the circumstances under which they are expected to arise. To gather the information presented below, we conducted additional interviews with pool administrative staff in Oregon, Minnesota, Louisiana, Wisconsin, and New Mexico as well as Medicaid program staff in Wisconsin and Minnesota.

4.1. Should the programs be coordinated?

One view is that there is, by definition, little overlap between the Medicaid and high-risk pool programs because they serve different purposes and populations: Medicaid eligibility is income based, and pools base eligibility on being unable to find coverage because of health conditions. One pool official noted that high-risk pools are intended to be an insurer of last resort and not part of a continuum of coverage for individuals as their income increases. In Wisconsin, the populations served by the pool and the state's publicly-funded coverage are very different. Enrollees in the Medicaid program and the state's more generous Badger Care program are generally younger adults with children, while the pool serves older individuals.

The argument to better coordinate the programs is that there may be some population that can be served through either the high-risk pool or the Medicaid program, but it is difficult to identify exactly what the potential population is. Wisconsin officials report that they are in the middle of a planning process to examine gaps in coverage (whether private-sector or publicly-sponsored) and this potential area of overlap between the pool and the public programs is one area that will be examined.

4.2. Program overlap

Whether or not one believes the programs should be coordinated, the operational need to coordinate will depend on the degree to which the target populations for each program overlap. One way to measure the likely overlap is by comparing the expected income distributions in the two programs. We have used the term "income distance" to refer to this contrast in income distributions.

Based on a review of states' Medicaid eligibility levels and high-risk pool premiums, the income distance between the two sources of coverage can be very little or very great. Therefore, the potential target population overlap can be significant or non-existent. Pool premiums range from 120 percent to 200 percent of standard market rate; the most common premium level is 150 percent. By comparison, Medicaid income eligibility levels range from 21 percent of the Federal Poverty Line

(FPL) to 275 percent of the FPL; the national average is 66 percent FPL.²⁸ Two extremes illustrate this range. Alabama's Medicaid eligibility level is the lowest in the nation and the high-risk pool premiums are among the highest. The Medicaid program covers families of three up to 21 percent FPL, and pool premiums are set at 200 percent of the standard market rate. By comparison, Minnesota has generous income eligibility guidelines for publicly-funded coverage and among the lowest premiums for the high-risk pool. MinnesotaCare covers pregnant women and children up to 275 percent FPL and childless adults up to 175 percent FPL, and pool premiums are statutorily capped at 125 percent of the standard market rate.

In addition to pool premium caps and eligibility rules for publicly-funded insurance, the income distance between the two programs is also affected by low-income subsidy programs for high-risk pools. Since most pools do not collect information on enrollees' incomes, it is difficult to know how many pool enrollees would qualify for a subsidy. However, based on the information we have, it is clear that at least some enrollees in every pool are low-income, and we can expect an even greater number in pools with subsidy programs. In pools with a subsidy program, the proportion of enrollees who qualify for the subsidy ranges from 13 percent to 35 percent. In Oregon for example, approximately 18 percent of pool enrollees receive a subsidy through FHIAP, which covers individuals up to 170 percent of the FPL. Wisconsin subsidizes pool enrollees with annual incomes of up to \$25,000, which represent 35 percent of pool enrollees. Non-subsidizing states include California, where 13 percent of the pool enrollees have incomes below 200 percent of the FPL, and Illinois, where 20 percent of pool enrollees reported annual incomes of less than \$20,000. Although Minnesota does not have a formal subsidy program, premiums are kept unusually low and pool staff found in a recent survey that 37 percent of pool enrollees reported incomes of less than 200 percent of the FPL.

Even in states where the target population overlap is potentially great, moving from the high-risk pool to Medicaid can be difficult. As state legislatures adopt higher income eligibility guidelines for publicly-funded coverage, there is greater concern that public coverage will supplant or "crowd-out" employer-sponsored coverage. One way to protect against such crowd-out is to require individuals to be without coverage for some time in order to qualify for publicly-sponsored coverage. MinnesotaCare requires applicants to be without coverage for 3 months and Wisconsin's Badger Care program requires applicants to be without coverage for 4 months. For people with chronic health conditions, going without coverage for 3 to 4 months or more is a high price to pay to qualify for a public program.

Such waiting periods are not permitted under Medicaid except through an 1115 waiver; however, they are allowed in certain SCHIP programs. States can adopt a separate SCHIP program (rather than a Medicaid expansion) and impose waiting periods to prevent "crowd-out" of private coverage. Of the 33 states that have adopted a separate SCHIP program, 29 impose a waiting period, and of those, 23 allow exceptions to the waiting period for designated groups, including children with special health care needs. This has implications for high-risk pools. States that have 1115 waivers for their

²⁸ Based on unpublished research from the Center for Budget and Policy Priorities, obtained from Matthew Broaddus, June 2001. Income eligibility levels cited are for a working parent with two children who is applying for publicly-funded coverage.

Medicaid programs (including Wisconsin and Minnesota) could also allow exceptions to their waiting periods for certain individuals for whom going without coverage would be an enormous burden. In fact, exempting pool enrollees from waiting periods for publicly-sponsored programs is an active pending issue in Minnesota. Pool officials there said they regularly ask Medicaid officials to exempt pool enrollees from the four month waiting period but have not yet been successful. Allowing eligible pool enrollees to move directly into the Medicaid program without having to go without coverage for four months could be of enormous benefit to the one-third of pool enrollees who are low-income.

4.3. Existing program coordination

Regardless of the income distance between the programs, the main focus of existing coordination between Medicaid and high-risk pools is to prevent individuals who are eligible for Medicaid from enrolling in the pool. In practice, however, “eligible” means actually enrolled in Medicaid because pools generally are not equipped to do income determinations. This most often means that pool staff will compare their enrollment lists to those of the Medicaid program and discontinue any pool enrollee who is found to be enrolled in Medicaid.

One notable exception is the Minnesota Comprehensive Health Association (MCHA). MCHA has no restrictions against Medicaid eligibility. In fact, MCHA enrollees may count their pool premiums and other cost-sharing expenses toward their “spend down” of personal resources to qualify for Medicaid.

By contrast, Louisiana has approximately eight cases in which individuals are enrolled in the pool for up to two years while awaiting an appeal of their denial of Medicaid eligibility. Once the person is determined to be eligible for the Medicaid program, the pool reimburses the premiums they paid back to the retroactive date of Medicaid eligibility. Oregon has changed its guidelines to provide continuity of coverage to individuals who become disqualified for Medicaid due to an increase in their income. Under pool guidelines, an individual leaving the pool cannot return for one year. However, this rule was waived for pool enrollees who move from the pool to the Medicaid program. If they are found to be ineligible for Medicaid within a year of leaving the pool, they may automatically re-enroll in the pool.

With regard to information sharing and program referrals, little coordination exists formally. For the most part, pool staff may provide information about publicly-funded programs if they know a pool enrollee is struggling to pay the premiums. Examples of more formal information sharing are found in Minnesota and Oregon. MCHA includes information on the Medicaid program in its annual premium increase notices, and the Minnesota Medicaid program has developed a brochure that includes MCHA among the options that are available for individuals denied Medicaid eligibility. In Oregon, Family Health Insurance Assistance Program (FHIAP) staff train eligibility workers at the Medicaid program and do outreach through providers that serve predominantly low-income and uninsured individuals. Pool coverage is one of the sources of coverage that can be subsidized through the state-funded FHIAP.

Beyond information sharing and referrals, some of the state officials we interviewed discussed programmatic and administrative coordination between the Medicaid and high-risk pool programs. In order to achieve administrative savings, Wisconsin's high-risk pool is administered from the same state agency that oversees the Medicaid and Badger Care programs.

4.4. Does having a high-risk pool reduce spending for public health insurance?

Additional policy questions arise in considering uninsurable individuals who might qualify for either high-risk pool coverage or Medicaid, depending on their health status, health expenses, and income. In states without a pool, how quickly do uninsurable individuals become impoverished enough to qualify for Medicaid? And in those states with high-risk pools, does the state save Medicaid spending because an individual can obtain coverage through the pool? Does the pool help the average uninsurable individual to avoid Medicaid for a meaningful amount of time? The answers to these questions can help a state decide whether to create a pool if one does not exist or expand an existing pool.

One way to expand a pool is to offer a premium subsidy program for low-income enrollees. One of the choices state legislatures make (albeit implicitly) when they enact a low-income subsidy program for the high-risk pool is that coverage through the pool is preferable to coverage through Medicaid. Although philosophical opposition to Medicaid is probably a more important factor, the question of relative cost to the state is also relevant to this choice.

State legislatures have made different choices at different times and have occasionally singled-out special populations. In New Mexico, the pool makes it possible for HIV-positive people and people-with-AIDS to avoid Medicaid. These individuals qualify for the Medicaid program based on their diagnoses, but the Medicaid program pays their premiums to obtain coverage through the high-risk pool. In contrast, Minnesota used to pay for pool coverage through the Medicaid program for some individuals, but this practice was discontinued in 1987. At the time, the pool received no public funds and pool losses were financed through assessments on insurers. Because claims exceeded premiums (including those paid through Medicaid) it was decided that private money should not be used to support a public program.

Several factors affect the relative cost to the state. In order to make this comparison, state legislatures must compare the per person cost of coverage for the pool to the per person cost of publicly-financed coverage, taking into account that portion which is funded by the state. For the Medicaid program, the state's portion of the cost is determined by the federal matching rate for the state's Medicaid outlays. The average federal share of Medicaid spending is 57 percent, with 43 percent paid by the state. For pools, the state portion of the cost of coverage will vary based on how the pool is financed and whether the state offers a subsidy program for low-income pool enrollees.

Pools typically finance less than 60 percent of operating costs through premiums, with the balance funded through a variety of sources. The most common source of non-premium funding is an assessment on insurers. If insurers can offset some or all of their assessment with credits against their state tax liability, the cost is shifted back onto the state. (See Appendix E for a table summarizing

pool financing mechanisms). In general, states that are most likely to experience reduced public health insurance spending are those with relatively small income distances between their high-risk pool and their public insurance programs, and those that finance their pool deficits primarily with private funds.

4.5. Conclusion

Although conceived to address different problems, high-risk pools and the Medicaid program sometimes come in contact with each other, especially in states with relatively generous Medicaid eligibility and/or low-income subsidies for their high-risk pools. Since the high-risk pool target population consists of individuals without access to group insurance who would be denied non-group coverage because of their health, the overlap with the Medicaid program is limited to similar individuals who also qualify for Medicaid—a small fraction of total Medicaid enrollment. In some states, however, the overlap could be a substantial fraction of pool enrollment (e.g., Wisconsin and Minnesota). Currently, coordination between these programs is minimal in most states (with exceptions in Wisconsin and Oregon), but as more state legislatures consider subsidy programs for high-risk pools and as Medicaid and SCHIP eligibility expands, more state policymakers will confront these issues.

The fundamental policy question state legislatures must then consider is: through which program would the state prefer individuals to obtain coverage? There are philosophical as well as practical considerations to be weighed in answering this question. State policies regarding high-risk pools and Medicaid expansions seem to imply a preference for individuals to retain private insurance and enroll in the pool if at all possible. For example, MinnesotaCare, Minnesota's Medicaid expansion, requires applicants to be without coverage for four months and limits benefits annually to \$10,000 per person. These represent significant barriers for individuals with chronic health conditions. Based on a recent survey, Minnesota pool staff found that 37 percent of pool enrollees reported incomes of less than 200 percent FPL. Many of those individuals would qualify for MinnesotaCare but they choose to remain in the pool as long as these barriers exist. However, it is not clear that this implied policy preference was consciously expressed. Policymakers may not have intended to apply anti-crowd out provisions to pool enrollees. In some State Children's Health Insurance Programs (SCHIP), states have made exceptions to their waiting periods for children with special health care needs. Such an exception could be made for individuals with chronic health conditions if legislatures decide that it is best, philosophically or financially, to provide coverage for these individuals through a publicly-sponsored program.

5. Case Studies in Sustainability

In this chapter we highlight high-risk pools with particularly interesting histories that shed light on the question of sustainability. We selected states that experienced either prolonged stability or periods of severe instability and attempted to identify some of the factors that contributed to their experience.

We start by considering some of the most stable high-risk pools, in Oregon and Minnesota. These pools have benefited from relatively strongly committed legislatures and low premium caps. Next, we consider Wisconsin and California, states with long pool histories that have experienced some periods of instability due to the funding mechanism in the case of California and an inability to adjust premiums smoothly in the case of Wisconsin. In the cases of Florida and Texas, we consider two states that have experienced substantial enrollment instability. Both states grew rapidly due to relatively low premiums in the early years of their pools. This growth contributed to closure of the pool to new enrollment in Florida, while the outcome in Texas has yet to be seen. Finally, we review experience in Washington, a state where dramatic changes in the private insurance market led to instability in the high-risk pool, regardless of decisions made by the pool's staff and board.

5.1. Oregon

The Oregon Medical Insurance Pool (OMIP) grew out of broader health reform efforts aimed at reducing the high number of uninsured Oregonians. A study of the uninsured recommended three different approaches—expand Medicaid, mandate employers to offer coverage to their workers, and create a high-risk pool for people denied health insurance because of their health status. The pool was passed in 1987 as one part of the multi-pronged Oregon Health Plan.

OMIP was originally created as a quasi-government agency but without any state funding, which essentially left insurers to assess themselves. Very little happened until 1989 when OMIP was made a state agency with \$1 million in start-up funds and a board authorized to assess insurers. Premiums are capped at 125 percent for medically-eligible enrollees and 100 percent for portability coverage, among the lowest premiums of all the high-risk pools. Enrollment has steadily grown to about 6,000 and the pool's loss ratio continues to run between 170 to 180 percent.

The most significant challenge to pool stability occurred in the early 1990s when SAFECO brought suit to challenge the state's assessment of stop-loss insurers in federal and state courts. The federal case challenged Oregon's authority to assess stop-loss insurers as a violation of ERISA's preemption of self-funded plans. The federal court found that the Oregon statute treats self-funded plans as insureds, not insurers, and that the assessment on stop-loss insurers relates only to insurance companies, not the self-funded plans they insure. The state court upheld Oregon's authority to assess a stop-loss insurer based on the number of lives insured. Together these two rulings established the legality of Oregon's assessment mechanism.

OMIP continues to be an integral part of the state's broader health care strategy. Pool coverage is coordinated with the state's subsidy program, the Family Health Insurance Assistance Program,

which was enacted in 1997 and subsidizes coverage for people with incomes up to 170 percent of the federal poverty level.

5.2. Minnesota

The Minnesota pool has several characteristics worthy of note. It operates one of the oldest, largest, most affordable, and most efficient high-risk pools in the country. The Minnesota Comprehensive Health Association (MCHA) was created in 1976 and became operational the following year. As of June 2000, MCHA had over 25,000 enrollees. Its popularity is due, in part, to its affordability. Its premium cap is among the lowest in the nation at 121% of individual market rates for the general pool and 125% for the Medicare supplement. Nevertheless, the state is considering a low-income subsidy program to assist those who cannot afford the MCHA premium. Finally, MCHA per enrollee administrative costs are generally below the national average.

MCHA has received funding from a variety of sources. During its first two years of operation, MCHA was funded through assessments of all health insurance plans with a 100% premium tax credit. In 1979 only the indemnity insurance carriers were required to pay the assessment. In 1987 HMOs, PPOs, fraternal organizations, and nonprofit health service plan corporations were again obligated to pay the assessment. Also that year the tax credit was revoked. In 1997 the Minnesota Legislature appropriated \$15 million for each of the next two years to MCHA to help offset losses. These funds came out of the state's "Health Care Access Fund" which had been funded through a 2% provider tax and was reduced to 1.5% in 1997. This tax is paid by providers and hospitals and passed on to insurance purchasers, including self-insured purchasers, and has withstood an ERISA challenge. In 2000 the Minnesota Legislature appropriated \$15 million to MCHA out of a surplus in the Minnesota's Workers Compensation Assigned Risk Plan. This funding mechanism has been challenged as unconstitutional and the case is still pending.

Despite the large variety of funding sources, the continuing growth of self-insured plans in Minnesota (now about 50% of all benefit plans) is expected to make it difficult to sustain funding as well as make future ERISA challenges more likely. Indeed, the state itself is now self-funding health care for state employees. From MCHA's perspective, this sets a worrisome example for other employers and presents a large financial problem for the pool. It also raises conflict of interest issues as the state attempts to collect funds from self-insured entities.

While MCHA is the state's HIPAA alternative, HIPAA had little impact because Minnesota enacted portability insurance reforms before HIPAA. Even without special provisions for HIPAA eligibles, most would be enrolled in MCHA anyway because there are many waiting period exceptions. On the other hand, small group reforms in the mid-1990s (i.e., guaranteed issue, limits on conversion policy rates) did have an impact on the number of MCHA enrollees but not a substantial impact on claims.

5.3. Wisconsin

Wisconsin's high-risk pool has an interesting history with its share of financial instability. It now has a hybrid funding mechanism that includes premiums, general revenue, assessments, and provider

discounts. This funding mechanism has proven to be too generous, leading to a surplus that carries its own political pressures, as explained below.

Wisconsin's Health Insurance Risk Sharing Plan (HIRSP) is among the oldest high-risk pools in the nation, established in 1981. It was the first high-risk pool to offer subsidies (beginning in 1985), that are partially funded out of state general revenue. The subsidy program provides a sliding-scale subsidy for premiums for individuals with annual incomes up to \$25,000 (individuals pay 130 percent of the standard rate if their income is between \$10,000 and \$25,000 or 100 percent of the standard rate if their income is \$10,000 or less). Individuals with annual income of up to \$20,000 also qualify for reduced deductibles. The regular \$1000 deductible is reduced on a sliding scale to \$500 for incomes up to \$10,000. The program has been used by about 35 percent of the pool membership, and is funded in part by a state appropriation (\$1.56 million for the 1999/2001 biennium), with the balance funded from assessments and adjustments to provider payments.

HIRSP has experienced several periods of financial instability. Originally, the program could not raise premiums without legislative approval. With the passage of time, premiums became very low relative to market rates, and the high-risk pool began attracting more enrollees than it could afford. Evidence of this can be seen in the pool's financial data. For example, in 1983 HIRSP had an unusually high loss ratio because collected premiums were very low relative to claims and administration costs.

In the early 1990s the funding mechanism was altered by legislation so that the program had to cover a certain amount of its expenses by premiums. This resulted in very rapid premium increases. For example, premiums increased an average of 28% in 1991, 27% in 1992, and 18% in 1993. Such rapid premium increases drove the healthier policy holders from the program and a death spiral commenced: increases in per-enrollee claims outpaced premium increases, necessitating further premium increases which further encouraged healthier enrollees to drop coverage.

In 1998 the legislature enacted a major administrative and financial overhaul of HIRSP. The program was moved from the Department of Insurance to the Department of Health and Family Services. The latter oversees the Medicaid program and the motivation was to leverage this administrative capability. The funding mechanism was also substantially altered. The new mechanism consists of four components:

1. The state contributes \$12 million annually from general revenue.
2. Sixty percent of the remaining costs are to be covered by premiums.
3. A portion of the remaining 40% of costs are to be covered by provider discounts.
4. The remainder is funded through assessments.

As a result of the 1998 reforms the program seems to be on a much more stable financial basis. In fact, funding has outpaced expenses in recent years, which might create pressure to reduce premiums and/or to cut assessments and general revenue contributions.

5.4. California

California has opted not to use its pool as the HIPAA alternative mechanism because it cannot financially support the number of potential HIPAA enrollees. Indeed, funding limitations have forced a cap on enrollment, as will be explained.

The California high-risk pool, known as the Managed Risk Medical Insurance Plan (MRMIP) is funded primarily by premiums and a limited stream of revenue from the Cigarette and Tobacco Surtax Fund (\$40 million per year since 1997). In 2000 MRMIP also received an additional \$5 million appropriation and a \$2 million grant. To avoid shortfalls, enrollment in the California pool is capped (at 19,815 in 2000 but expected to drop to 15,000 in 2001) and the waiting list has grown quite large to 4,000 individuals, each expected to have to wait about one year. Despite the complete absence of marketing efforts, the waiting list is expected to continue at maximal levels for the foreseeable future.

To serve those on the waiting list, both Blue Cross of California and Blue Shield of California have offered, until recently, “look-alike” programs with coverage comparable to the high-risk pool at unsubsidized rates. About 80% of individuals on the waiting list for MRMIP purchased a look-alike policy. Recently, Blue Cross has changed the benefits package associated with these programs so they conform to their other products and not to MRMIP. The governor of California and the high-risk pool board have decided to address additional problems of access to health insurance and to satisfy HIPAA requirements through market reforms rather than through the high-risk pool. Given the lack of political support for additional funding for the high-risk pool in California, it is unlikely that California will seek to have its high-risk pool accepted as a state alternative mechanism for HIPAA.

Despite insurance market reforms and partly due to MRMIP’s enrollment cap, California has a large uninsured population with 24% of residents lacking health insurance. An estimated 2.5% to 5% of this uninsured population is uninsurable due to medical conditions. This translates to as many as 123,000 individuals in the population potentially served by MRMIP. Other estimates have put the figure closer to 300,000.

5.5. Florida

The Florida Comprehensive Health Association (FCHA) began in 1983 as the State Comprehensive Health Association. Enrollment in the pool was slow until the late 1980s when it began to grow quickly, prompted in part by a Department of Insurance rule requiring insurers to notify people turned down for insurance about the existence of the pool. The pool was funded by an assessment with an offset, until 1989 when the tax credit was eliminated because of state budget problems.

During this time, the pool’s costs were growing while the rates stayed about the same, resulting in rapidly increasing losses for the pool. In 1990, the year after the tax credit was eliminated, the assessment nearly doubled to more than \$33 million. The insurance industry and advocates clashed over a legislative response, ultimately leading to legislation to reorganize the pool with managed care options, rename it as FCHA, and close the pool to new enrollment. The board also changed from a

nine-member board with an industry majority to the current three-member board, made up of the Insurance Commissioner, a policyholder and an industry representative.

With this change, premiums were increased from 150 percent of the standard market rate to up to 250 percent for high-risk individuals (based on underwriting). Enrollees' rates could be adjusted down annually through an appeals process, to 225 percent for medium-risk and to 200 percent for low-risk. Enrollment dropped drastically over the last decade, from a high of 7,500 in 1990 to just 800 in 1999.

There have been attempts to reopen the pool, including an unsuccessful legislative proposal last year to shift the funding from an assessment to an endowment made up of either general revenue or tobacco settlement money. The Commissioner of Insurance has submitted a legislative proposal for consideration this session to fund the pool from a surcharge on insurance policies, including those issued by stop-loss insurers. The surcharge would be \$1 per enrollee per month. The proposal would also reconstitute the board and open the pool to HIPAA eligibles. An industry representative said they would support reopening the pool if the funding mechanism is broad-based rather than an assessment, which can reach only one-third of the plans in Florida because of ERISA exemptions.

5.6. Texas

The Texas pool began operating in 1998 in direct response to HIPAA. Since then, it has experienced explosive growth and the financing difficulty associated with it. Although legislation to create the Texas Health Insurance Risk Pool passed in 1989, no start-up funding was provided. In 1997, sufficient funding was appropriated and the pool began issuing policies in 1998 as the state's HIPAA alternative.

The Texas pool has experienced extremely rapid growth in enrollment, claims, and carrier assessments. As of the end of 2000, enrollment had reached 11,000, up from 6,660 in 1999. Claims grew four-fold between 1998 and 1999, as have assessments. This rapid growth is, perhaps, the biggest threat to the pool as insurers have already begun to complain about the size of assessments. As additional evidence of potentially destabilizing growth: premiums have increased each year; they began at 137% of market rates in 1998, increased to 150% and will go up to 165% in 2001.

While nothing explicit has yet been done to tackle problems associated with rapid growth, there is talk of an effort to propose a premium tax credit to offset assessments. In addition, some are considering an enrollment cap for non-HIPAA-eligibles and assessing stop-loss carriers on a per capita basis. To help control costs, Texas already has contracts with managed care networks and pharmacy benefit managers.

5.7. Washington

Washington state has a history of health care reform efforts, and those broader efforts have had an effect on who enrolls in the Washington State Health Insurance Pool (WSHIP). The Health Care Access Act passed in 1987; among other provisions, it provided for the creation of WSHIP. Rates

were set at a maximum of 150 percent, or 125 percent for those enrolled in managed care plans. Enrollment climbed to a high of 4,400 in 1993.

The Health Reform Act of 1993 sought to achieve universal coverage through comprehensive individual and small group insurance market reform and an employer mandate. With these market reforms, people began moving to the commercial market and enrollment in the pool dropped 70 percent in one year, to 1,300. Those that remained in the pool were the sickest enrollees, typically people with HIV/AIDS or organ transplants, possibly because they didn't trust that the market would remain. The per member cost of the pool climbed as the healthiest enrollees left.

That changed when the market began to change. Many of the reforms enacted in 1993 were repealed in 1995 and the non-group market began to deteriorate. In mid-1999, three large plans left in the same week, leaving only two small plans with scaled-back products in limited areas of the state. The Insurance Commissioner issued a rule that established a new eligibility path to the pool for people in counties without a plan. Enrollment in the pool grew from fewer than 800 enrollees who were primarily Medicare disability-eligibles to 2,200 enrollees who are primarily non-Medicare.

The state sought to revive the non-group market with another set of comprehensive legislation enacted in March 2000. This time, the pool was directly affected by the legislation, with changes in rates and funding. The 2000 legislation establishes discounted premiums for 50 to 64-year olds under 300 percent of the federal poverty level. However, only \$200,000 was appropriated in the biennium for the discounts, so pool officials do not expect many can be covered under this program. The state is currently developing an application process for the discount (which will be administered from a separate agency that has experience with income-based subsidies). Another discount was established to reward tenure in the pool. People who are enrolled in the pool for more than 36 months will qualify for a five percent discount. The legislation also allows the pool to assess stop-loss plans based on one in 10 insured through the plans.

Another provision is expected to directly affect the pool. The legislation allows insurers to use a health screen to send eight percent of applicants to the pool. The screen has recently been put in use but it is too soon to tell how the pool will be affected in terms of enrollment.

6. Impact of HIPAA

In this chapter we comment on some phenomena that have been influenced by the passage of HIPAA. It should be noted, however, that our ability to observe and to draw conclusions about the effect of HIPAA is limited by the available data. Our primary data source, Communicating for Agriculture, does not consistently report state statistics by eligibility type. In other words, statistics on individuals who are enrolled in a state's high-risk pool because they are eligible under HIPAA are combined with those who are enrolled for other reasons. Consequently, we cannot observe enrollment or claims (to take just two examples) for HIPAA enrollees distinct from others. To be sure, some states (e.g., Illinois) report some statistics (typically just enrollment) broken out by eligibility type. This is more common among states that have separate pools for HIPAA and non-HIPAA eligibles. However, since the breakdown is not consistent across all states, we could not conduct analysis by eligibility type.

A second limitation of Communicating for Agriculture data is that it is self-reported. Pools are free to use their own definitions for data elements (e.g., administrative costs). Further, the definition that each pool uses for each data element is undocumented. While the data are still useful, some kinds of analysis are not possible without greater consistency.

A third factor that limits our ability to draw conclusions about the effect of HIPAA is that HIPAA was enacted relatively recently and states' responses are more recent still. Most states implemented high-risk pool eligibility for HIPAA-qualifying individuals in 1997 and some in 1998. Since complete data are only available through 1999, this provides only two or three years of post-HIPAA data.

Despite these limitations, there is qualitative evidence that HIPAA encouraged the growth of most existing pools and the creation of some new pools, particularly in Alabama and Texas. The exception is in states that decided not to use their high-risk pools as the HIPAA alternative. These states are discussed below.

California, Colorado, and Missouri have chosen to be "federal fallback states" despite having high-risk pools already in operation. Given that other states have chosen to use their high-risk pools to comply with HIPAA, the question arises as to what is different about these three. In the case of California, the pool deficit is funded by a limited stream of revenue from the Cigarette and Tobacco Surtax Fund (\$40 million per year since 1997). In 2000 MRMIP also received an additional \$5 million appropriation and a \$2 million grant. To avoid shortfalls, enrollment in the California pool is capped (at 19,815 in 2000 but expected to drop to 15,000) and the waiting list has grown quite large (with 4,000 individual each expected to have to wait about one year). Despite the complete absence of marketing efforts, the waiting list is expected to continue at maximal levels for the foreseeable future.

The governor of California and the high-risk pool board have decided to address additional problems of access to health insurance and to satisfy HIPAA regulations through market reforms rather than

through the high-risk pool. Given the lack of political support for additional funding for the high-risk pool in California, it is unlikely that California will seek to have its high-risk pool accepted as a state alternative mechanism.

Circumstances in Colorado, however, are more favorable. The Colorado Legislature passed the Colorado Uninsurable Health Insurance Plan in 1990. However, when HIPAA was implemented, despite already having many of the HIPAA reforms in place, Colorado adopted the “federal fallback” position rather than utilizing the high-risk pool as the state alternative mechanism. One clue to why is given by concerns raised by the Colorado Division of Insurance about HIPAA regarding lack of flexibility and lack of clarity and simplicity in the law and subsequent regulations. For example, Colorado has raised concerns that other experience, such as the State Children’s Health Insurance Program has offered greater flexibility to states in administration. Another concern is that the rules of HIPAA are not as straightforward as the COBRA regulations. Despite these concerns, the Executive Director of the Colorado pool indicated that they may soon apply to be certified as a state alternative mechanism and they are interested in learning more about the process.

Missouri also chose not to use its high-risk pool for HIPAA compliance and is, instead, a federal fallback state. According to a representative of the Department of Insurance (DOI), the pool had low enrollment from its inception and so was not considered effective. DOI decided there were provisions in HIPAA that “took steps to improve availability and accessibility that were better than the other alternatives states were given.”

7. Quantitative Results

This chapter uses the quantitative database described in Section 2.3 to investigate the problem of the uninsured and uninsurable, the extent to which high-risk pools address this problem, the affordability of high-risk pools, and the future size and fiscal stability of high-risk pools. We begin with a presentation and discussion of the numbers of uninsured and uninsurable, by state. Next is a discussion of the impact that high-risk pools have had on the size of the uninsurable population. Following that, we focus on the level of high-risk pool premiums and the affordability of those premiums. Multivariate analysis presented in this chapter indicates that further subsidization of high-risk pool premiums could increase enrollment and further reduce the number of uninsurable persons.

This chapter also documents the large deficits (costs less collected premiums) associated with high-risk pools. Deficits highlight the tension observed in our interviews, and discussed in Chapter 3, between the desire to provide additional coverage and the need to manage collective funds (either public or industry provided).

The main conclusion of the quantitative analysis presented in this chapter is that, despite the steady growth over the last 20 years in the number of states with high-risk pools, the total number of high-risk pool enrollees is a very small fraction of the population such pools are designed to serve (the uninsurable population). At the same time, high-risk pools remain unaffordable to many who have no other source of coverage. Additionally, high-risk pool deficits (costs net premiums) have been rising dramatically, signaling a potential funding crisis. Therefore, while there is considerable opportunity for growth in number and size of high-risk pools, there are significant financial barriers to growth. The results in this chapter support this story as well as the following key points:

- Nationally in 1998, 2.5 million or about 6% of uninsured individuals are uninsurable due to medical underwriting.
- Nationally in 1998, high-risk pools enrolled about 90,000 individuals or about 3.5% of the uninsurable population.
- Pools are affordable to many though not all of the uninsured and uninsurable. In the 15 states for which data are available, the pool premiums represented less than ten percent of family income for only 50 percent of uninsured individuals.
- Reducing pool premiums has the potential to raise pool enrollment dramatically. A ten percent premium cut could be expected to generate at least a ten percent increase in pool enrollment. Nevertheless, because pool enrollments are small relative to their target population (the uninsurable), even dramatic cuts in premiums would not have dramatic impacts on the size of this population although they might be critically important to the additional individuals who obtained coverage.

7.1. The Problem of the Uninsured

High-risk pools are intended to address a part (and, as will be shown, a very small part) of the problem of the uninsured. One way to gauge how well high-risk pools are doing is to compute the ratio of high-risk pool enrollment to the target population (the number of uninsurable). This section

focuses on the denominator—the number of uninsurable individuals. The numerator—high-risk pool enrollment—is the topic of Section 7.2. Since the uninsurable are a sub-population of the uninsured, this section begins with an examination of the number of uninsured by state. All figures presented in this section were derived from the project database constructed as described in Section 2.3.

The growing number of uninsured individuals is a well-recognized problem in the U.S. About 43 million individuals did not have health insurance in 1998, representing 16% of the U.S. population (Table 7.1). The number of uninsured individuals and the proportion of the population they represent vary widely by state. In 1998, Minnesota had the lowest uninsurance rate, with 8.8% of the state's population uninsured, as shown in Table 7.1. Texas had the highest uninsurance rate, at 24.1%.

Interestingly, the rate of increase in the number of uninsured has been declining in recent years. In the mid-1990s the annual rate of increase in the number of uninsured was about 3%. Between 1997 and 1998, the rate fell to about 0.6%. This could be due to the influence of HIPAA, to state-level insurance reforms, and to the state of the economy (with the rate of increase in uninsurance slowing as individuals obtained employment and employer-based coverage at higher rates).

There is no simple relationship between a state's uninsurance rate and the existence of a state high-risk pool. As shown in Table 7.1, states with high-risk pools (shown in **bold** in Table 7.1) have both high and low rates of uninsurance. Indeed, both Minnesota and Texas (which have the lowest and highest uninsurance rates, respectively) had high-risk pools in 1998.²⁹ It is not altogether surprising that no clear relationship exists between the uninsurance rate and high-risk pool presence because high-risk pools tend to enroll very few individuals. In fact, as we will show, the target population for high-risk pools is *much* smaller than the uninsured population.

Table 7.1

Number and percent of population uninsured by state in 1998^(a)

<i>State</i>	<i>Number</i>	<i>Percent of Population</i>
United States	43,429,979	16.0%
Alabama	668,149	15.6%
Alaska	116,027	18.2%
Arizona	1,120,830	23.3%
Arkansas	498,257	19.3%
California	7,124,360	21.3%
Colorado	633,588	15.7%
Connecticut	378,190	11.4%
Delaware	100,378	13.1%
District of Columbia	83,536	16.2%
Florida	2,756,968	18.7%

²⁹ It should be noted that the Texas high-risk pool became operational in 1998, whereas Minnesota's pool has been in operation since 1976. It might be argued that if a relationship exists between the uninsurance rate and high-risk pool presence, it would not be evident in the 1998 Texas data because the pool was so new. However, New Mexico, which has had a high-risk pool since 1988, has an uninsurance rate close to that of Texas (23.1%, the third highest among all states).

Table 7.1**Number and percent of population uninsured by state in 1998^(a)**

Georgia	1,314,948	17.1%
Hawaii	114,864	9.6%
Idaho	229,556	18.2%
Illinois	1,688,506	13.9%
Indiana	715,181	12.2%
Iowa	279,768	9.9%
Kansas	297,099	11.4%
Kentucky	566,061	14.5%
Louisiana	870,727	20.3%
Maine	164,569	13.1%
Maryland	703,928	13.9%
Massachusetts	676,672	11.1%
Michigan	1,197,754	12.0%
Minnesota	424,348	8.8%
Mississippi	520,802	18.9%
Missouri	570,538	10.6%
Montana	174,494	19.3%
Nebraska	171,213	10.2%
Nevada	365,479	19.9%
New Hampshire	135,504	11.1%
New Jersey	1,246,209	15.5%
New Mexico	420,687	23.1%
New York	3,131,838	17.1%
North Carolina	1,135,425	15.3%
North Dakota	87,109	13.7%
Ohio	1,237,820	11.0%
Oklahoma	589,664	17.9%
Oregon	470,701	14.0%
Pennsylvania	1,189,447	10.0%
Rhode Island	87,019	9.0%
South Carolina	636,069	16.6%
South Dakota	89,210	12.6%
Tennessee	707,528	12.7%
Texas	4,793,249	24.1%
Utah	293,019	13.9%
Vermont	62,631	10.6%
Virginia	922,223	13.6%
Washington	752,558	13.1%
West Virginia	300,474	17.2%
Wisconsin	535,879	10.3%
Wyoming	78,925	16.2%

(a) Though figures are available for 1999, to obtain accurate state-level results, we averaged data from 1997, 1998, and 1999. **Bold** indicates a state with a high-risk pool as of 1998.

Sources: U.S. Census Bureau, Current Population Survey, March 1998, 1999, 2000.

An often-cited rule-of-thumb is that 1% of the uninsured are uninsurable due to medical conditions (i.e., they cannot pass typical medical underwriting screens).³⁰ However, after an extensive search of the literature, the Project Team could not find any empirical evidence for this rule-of-thumb. Moreover, this figure is not consistent with results cited by the State of California which reports that between 2.5% and 5% of California's uninsured are uninsurable due to medical underwriting.³¹ Our own estimates are closer to the California figure (Table 7.2).³² Roughly speaking, we find that while 1% of the population (which includes both the insured and uninsured) is uninsurable, about 6% of the uninsured are uninsurable.

In recent years, the number of uninsurable individuals has been declining. The rate of decline has been close to 2% over the period 1996-1998. Reasons for the decline in the number of uninsurable individuals include those likely responsible for the slowing rate of increase in the number of uninsured: HIPAA, state insurance reform, and the growing job market. In addition, high-risk pools have contributed, in small part, to the reduction in the number of uninsurable individuals.

The uninsurable rate does vary by state but the range of variation is considerably smaller as compared to the uninsurance rate. In 1998, the uninsurable rate was lowest in Hawaii (0.34% of the population and 3.6% of the uninsured were uninsurable) though Minnesota has very similar numbers (0.34% and 3.9%). West Virginia and Oklahoma had the highest uninsurable rates in 1998. In West Virginia 1.64% of the population and 9.5% of the uninsured were uninsurable while in Oklahoma 1.66% of the population and 9.3% of the uninsured were uninsurable.

Again, as with the uninsurance rate, there is no clear, simple relationship between the uninsurable rate and the presence of a high-risk pool. Both Minnesota, which has a low uninsurable rate, and Oklahoma, which has a high uninsurable rate, had high-risk pools in operation in 1998 (states with a high-risk pool in 1998 are shown in **bold** in Table 7.2).

Caution is warranted when considering state-level estimates of the uninsurable population. While the Project Team has taken measures to produce the best possible state-level estimates of the uninsurable population, they are not as reliable as those of the uninsured. First, our operational definition of uninsurable is less than ideal, though the best possible given the available data (see the footnote of Table 7.2 for our operational definition). Because our operational definition is so constrained by data availability, characteristics of the uninsurable, like income, are likewise to be used with caution. It is probable that a significantly different income distribution would result if a different definition were employed, even if it produced the same or a similar estimate of the uninsurable population.

³⁰ See, for example, Bovbjerg, R.R., and C.F. Koller, "State Health Insurance Pools: Current Performance, Future Prospects," *Inquiry* 23:111-121, Summer, 1986.

³¹ Hunt, S., "Individual Health Insurance Options for California," produced by Pricewaterhouse Coopers for the California Managed Risk Medical Insurance Board, September, 2000.

³² Our estimate was constructed using the CPS. An individual is considered uninsurable if he is uninsured and cannot work or is limited in the type of work that he can do or receives any disability or worker's compensation income. While this is not the ideal operational definition of uninsurable, it is the best that can be obtained using the data available to the Project Team.

Second, given that uninsurability is an infrequent occurrence, sample sizes are small, though we have addressed this problem somewhat by pooling three years of CPS data to produce our estimates. Third, there are few good sources to validate our work. While there are many estimates of the uninsured available in the literature, an extensive search for relatively recent data-based estimates of the uninsurable found nothing. Despite these warnings, the estimates produced by the Project Team are, to our knowledge, the best currently available.

Table 7.2

Number and percent uninsurable^(a) by state in 1998^(b)

<i>State</i>	<i>Number</i>	<i>Percent of Population</i>	<i>Percent of Uninsured</i>
United States	2,541,434	0.94%	5.9%
Alabama	54,199	1.26%	8.1%
Alaska	9,139	1.43%	7.9%
Arizona	45,928	0.95%	4.1%
Arkansas	41,325	1.60%	8.3%
California	318,553	0.95%	4.5%
Colorado	35,195	0.87%	5.6%
Connecticut	21,119	0.64%	5.6%
Delaware	5,957	0.78%	5.9%
District of Columbia	5,793	1.12%	6.9%
Florida	141,486	0.96%	5.1%
Georgia	69,689	0.90%	5.3%
Hawaii	4,098	0.34%	3.6%
Idaho	13,261	1.05%	5.8%
Illinois	101,358	0.83%	6.0%
Indiana	51,416	0.88%	7.2%
Iowa	16,530	0.58%	5.9%
Kansas	23,842	0.91%	8.0%
Kentucky	45,790	1.18%	8.1%
Louisiana	52,687	1.23%	6.1%
Maine	13,163	1.05%	8.0%
Maryland	31,188	0.62%	4.4%
Massachusetts	45,109	0.74%	6.7%
Michigan	83,397	0.84%	7.0%
Minnesota	16,456	0.34%	3.9%
Mississippi	31,914	1.16%	6.1%
Missouri	41,987	0.78%	7.4%
Montana	12,814	1.41%	7.3%
Nebraska	9,095	0.54%	5.3%
Nevada	19,309	1.05%	5.3%
New Hampshire	8,834	0.72%	6.5%
New Jersey	75,594	0.94%	6.1%
New Mexico	20,537	1.13%	4.9%
New York	177,744	0.97%	5.7%
North Carolina	80,613	1.09%	7.1%
North Dakota	6,202	0.98%	7.1%
Ohio	104,065	0.93%	8.4%
Oklahoma	54,806	1.66%	9.3%
Oregon	23,229	0.69%	4.9%

Table 7.2**Number and percent uninsurable^(a) by state in 1998^(b)**

Pennsylvania	79,217	0.67%	6.7%
Rhode Island	7,198	0.75%	8.3%
South Carolina	47,232	1.23%	7.4%
South Dakota	5,990	0.84%	6.7%
Tennessee	51,332	0.92%	7.3%
Texas	220,385	1.11%	4.6%
Utah	18,608	0.88%	6.4%
Vermont	4,689	0.79%	7.5%
Virginia	62,122	0.92%	6.7%
Washington	48,268	0.84%	6.4%
West Virginia	28,668	1.64%	9.5%
Wisconsin	49,231	0.94%	9.2%
Wyoming	5,077	1.04%	6.4%

(a) An individual is considered uninsurable if he is uninsured and cannot work or is limited in the type of work that he can do or receives any disability or worker's compensation income.

(b) Though figures are available for 1999, to obtain accurate state-level results, we averaged data from 1997, 1998, and 1999. **Bold** indicates a state with a high-risk pool as of 1998.

Sources: U.S. Census Bureau, Current Population Survey, March 1998, 1999, 2000.

7.2. Part of the Solution: High-Risk Pools

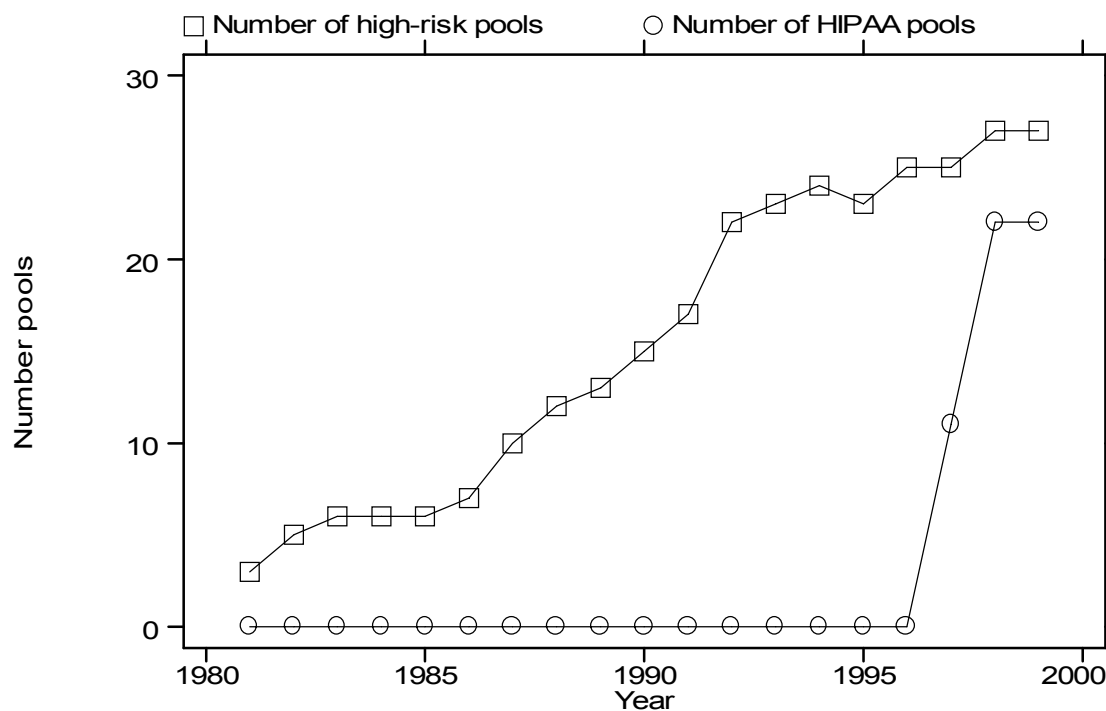
High-risk pools are intended to solve a small part of the problem of the uninsured. Their target population is the uninsurable. High-risk pools offer insurance at above-market premiums (that are capped by statute) to those who are excluded from the individual insurance market due to medical underwriting. In this section we present descriptive statistics that illustrate the progress high-risk pools have made toward fulfilling their intended role.

In 1981, three states had high-risk pools: Minnesota, Connecticut, and Wisconsin. From 1981 to 1999, the number of states with high-risk pools increased nearly every year, reaching a high of 27 in 1999. The sole exception to the steady increase occurred in 1995, when the number of high-risk pools declined by one from the 1994 level. This decline occurred because Tennessee folded its high-risk pool into TennCare³³ in 1995. Figure 7.1 illustrates the increasing number of high-risk pools. Figure 7.1 also shows the number of those pools that act as the state HIPAA alternative mechanism. By 1999, 22 of the 27 high-risk pools were HIPAA pools. The five exceptions were California, Colorado, Florida, Missouri, and Washington.

³³ TennCare is Tennessee's health insurance program for the low-income and uninsurable population, including the Medicaid-eligible population. Because the uninsurable population is just a small part of TennCare's overall target population, it does not operate like a standard high-risk pool and should not be viewed as one.

Figure 7.1

Number of states with high-risk pools and the number of HIPAA pools by year



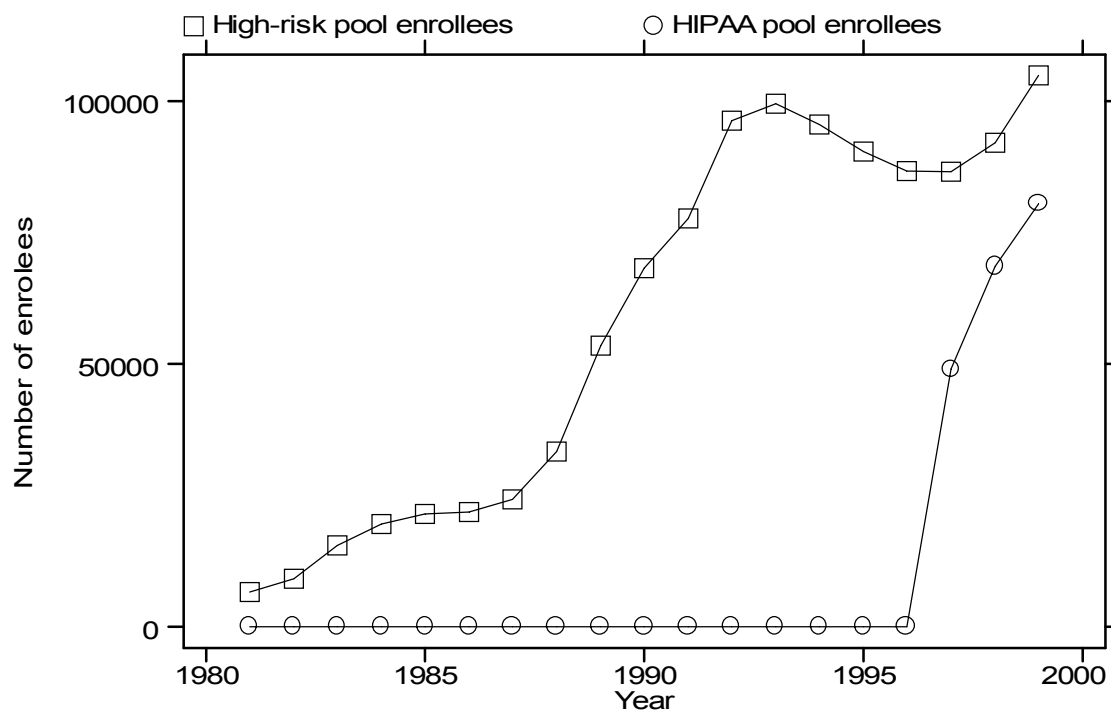
Sources: *Communicating for Agriculture Inc.*, “*Comprehensive Health Insurance for High-Risk Individuals*”, 2000.

Corresponding to the growth in the number of states with high-risk pools, there has been nearly steady growth in the number of individuals participating in high-risk pools. As shown in Figure 7.2, the number of high-risk pool enrollees grew to over 100,000 in 1999. Also as shown in Figure 7.2, there was a decrease in the number of high-risk pool enrollees in only one period: 1994-1996. This decrease coincides with two phenomena. First, as mentioned, Tennessee folded its high-risk pool into TennCare in 1995. This accounts for a large part of the decrease in 1995. Second, small-group and non-group insurance reforms passed in many states in the mid-1990s, and these may have improved access to private insurance and thus reduced demand for coverage through high-risk pools.

The resumption of growth in high-risk pool enrollment in the late 1990s coincides with the passage of HIPAA in 1996 and subsequent compliance by the states. Since 1997, growth in high-risk pool enrollment has been particularly vigorous. The annual growth rate was 6.4% in 1998 and nearly 14% in 1999. These growth rates are far faster than the growth rate in the number of uninsured and the number of uninsurable. (Recall that the growth rate of the latter was negative indicating a recent reduction in the number of uninsurable.) Consequently, in recent years at least, high-risk pools have covered an increasing number of the uninsured and uninsurable each year. Despite this recent growth, only a small proportion of the uninsurable population is served by high-risk pools. In 1998, high-risk pool enrollment represented only 3.5% of the national uninsurable population and 6.1% of the uninsurable population living in high-risk pool states.

Figure 7.2

National total enrollment in high-risk pools and in HIPAA pools by year



Sources: *Communicating for Agriculture Inc., "Comprehensive Health Insurance for High-Risk Individuals," 2000.*

Also shown in Figure 7.2 is the number of enrollees in high-risk pools that are used as HIPAA alternative mechanisms. Note that this number represents the total count of all high-risk pool enrollees in all states that use a high-risk pool as a HIPAA alternative mechanism and is not a count of just the HIPAA-eligible enrollees. While the latter statistic would be informative, it cannot be computed with available data.³⁴ Figure 7.2 shows that by 1999 enrollees in a HIPAA pool accounted for about 75% of all high-risk pool enrollees (about 75,000 of a total of 100,000). This reflects the fact that most states use a high-risk pool as the HIPAA alternative, as shown in Figure 7.1. Most of the difference in 1999 between enrollment in any kind of high-risk pool and enrollment in a HIPAA pool is due to the fact that California does not use its pool to satisfy HIPAA. California's pool has just under 21,000 enrollees.

³⁴ Some states that use a high-risk pool to satisfy HIPAA have formed two separate pools, one for HIPAA eligibles and one for all other eligibles. Other states that use a high-risk pool to satisfy HIPAA have just one pool that includes both kinds of eligibles. Due to the way data are reported by Communicating for Agriculture, we cannot distinguish between the two. Therefore, when we refer to HIPAA pool enrollees we are including all high-risk pool enrollees in a state that uses a high-risk pool for HIPAA, regardless of eligibility status. It is therefore more difficult to identify the effects of HIPAA on pool operations than it would be if separate statistics were kept.

7.3. Pool Affordability

Technically speaking, high-risk pools improve access to health insurance by offering coverage to individuals who are unable to buy it on the private market due to pre-existing conditions. Practically speaking, individuals will not purchase the insurance unless it is attractively priced relative to the costs and risks of being uninsured. In fact, many would argue that health insurance is not accessible unless it is affordable. This section examines high-risk pool premiums and comments on their affordability. Attention is focused solely on the 15 states that provided premium pricing information to Communicating for Agriculture in 1999.³⁵ We will call this group of 15 states the “focus states.”

As Table 7.3 shows, there was a wide range in the reported monthly premiums among the focus states. A 35 year old male non-smoker would pay \$118 for an individual, no frills policy with the lowest deductible available in Minnesota and \$389 for the parallel policy in Alaska. Across the focus states, the mean premium was \$225. Also shown in Table 7.3, for the focus states, mean annual family incomes ranged from \$42,000 to \$65,000. Mean family incomes were lower for the uninsured, \$26,000 to \$41,000, and for the uninsurable, \$19,000 to \$41,000.

Table 7.3
Focus State Premiums and Mean Family Income By State, 1999

State	Premium	Subsidy	Mean Family Income			Premium as Percent of Family Income ^(a)		
			All	Uninsured	Uninsurable	All	Uninsured	Uninsurable
AK	\$389	No	\$65,000	\$41,000	\$42,000	7%	11%	11%
AL	\$170	No	\$47,000	\$32,000	\$20,000	4%	6%	10%
AR	\$149	No	\$42,000	\$26,000	\$19,000	4%	7%	9%
CA	\$245	No	\$58,000	\$36,000	\$31,000	5%	8%	9%
CO	\$208	Yes	\$62,000	\$37,000	\$35,000	4%	7%	7%
IL	\$280	No	\$62,000	\$41,000	\$24,000	5%	8%	14%
KS	\$333	No	\$54,000	\$26,000	\$34,000	7%	15%	12%
MN	\$118	No	\$64,000	\$41,000	\$40,000	2%	3%	4%
MS	\$209	No	\$45,000	\$30,000	\$26,000	6%	8%	10%
MT	\$243	No	\$42,000	\$27,000	\$26,000	7%	11%	11%
ND	\$201	No	\$44,000	\$35,000	\$24,000	5%	7%	10%
NM	\$196	Yes	\$43,000	\$29,000	\$24,000	5%	8%	10%
OK	\$188	No	\$49,000	\$31,000	\$22,000	5%	7%	10%
TX	\$191	No	\$52,000	\$32,000	\$20,000	4%	7%	11%
WA	\$259	Yes	\$59,000	\$42,000	\$40,000	5%	7%	8%

^(a) Premium is for a 35-year-old non-smoking male who purchases an individual policy with the lowest deductible offered and no optional features. Deductibles and benefits vary by state. Income is family income. The uninsurable are defined as described in Section 7.1.

Sources: Communicating for Agriculture (premiums and subsidies); CPS (family income)

For many uninsured or uninsurable individuals, purchasing insurance through the pool would be a significant expense. Excluding Minnesota, individual premiums varied from 4 to 7 percent of mean

³⁵ While all pool states provided information to C for A on total premium revenue, only 15 states provided a premium schedule. We used a low-deductible, no-frills policy for an age 35 non-smoking male.

family income and from 6 and 15 percent of the mean family income for uninsured or uninsurable individuals. Minnesota represented a significant outlier with premiums representing 2 percent of mean family income and 3 and 4 percent of mean family income for the uninsured and uninsurable respectively.

Considering mean family incomes masks the within-population variance in income. Another way to examine the issue of affordability is to examine the percentage of the population for whom premiums represent some threshold percentages of family income. Across the 15 focus states, for 70 percent of individuals, 50 percent of uninsured individuals, and 27 percent of uninsurable individuals, the premium for a 35 year old male represented less than 10 percent of family income.³⁶ (See Table 7.4.)

Table 7.4							
Percent of Population for whom Premium was either Less than 10 percent or more than 25 percent of Family Income, 1999							
<i>state</i>	<i>premium</i>	<i>individuals</i>		<i>uninsured</i>		<i>uninsurable</i>	
		<i>>25</i>	<i><10</i>	<i>>25</i>	<i><10</i>	<i>>25</i>	<i><10</i>
Alaska	\$389	8.44%	72.38%	19.06%	52.76%	12.24%	32.68%
Alabama	\$170	12.91%	54.44%	28.45%	33.63%	36.39%	38.06%
Arkansas	\$149	6.46%	77.15%	14.46%	60.57%	12.64%	44.18%
California	\$245	9.69%	65.58%	16.46%	46.35%	30.88%	41.16%
Colorado	\$208	5.96%	78.53%	11.17%	55.71%	27.42%	53.78%
Illinois	\$280	10.93%	68.24%	21.67%	46.19%	37.53%	27.10%
Kansas	\$333	17.37%	54.82%	39.08%	20.37%	50.54%	38.38%
Minnesota	\$118	1.86%	90.72%	4.32%	83.38%	0.00%	85.90%
Mississippi	\$209	12.23%	64.57%	22.58%	47.55%	27.07%	54.35%
Montana	\$243	12.81%	56.23%	22.86%	37.37%	29.95%	35.08%
New Mexico	\$201	9.16%	64.32%	14.08%	48.91%	25.77%	55.11%
North Dakota	\$196	9.56%	66.22%	18.82%	51.87%	16.84%	52.58%
Oklahoma	\$188	8.80%	72.30%	13.27%	60.29%	30.19%	46.26%
Texas	\$191	8.19%	71.79%	13.78%	54.70%	19.70%	46.16%
Washington	\$259	9.60%	69.83%	17.38%	51.28%	18.20%	52.33%
Wyoming	\$158	4.94%	79.93%	11.48%	62.06%	17.19%	54.20%
ALL THESE STATES		9.13%	69.52%	16.41%	50.33%	26.74%	43.45%

Premium is for a 35-year-old non-smoking male who purchases an individual policy with the lowest deductible offered and no optional features. Deductibles and benefits vary by state.

Income is family income. The uninsurable are defined as described in Section 7.1. Because of low numbers of uninsurable individuals in the sample, individual state percentages may be imprecisely measured.

Table only includes states that furnished premium information.

Sources: Communicating for Agriculture (premiums), CPS (family income).

³⁶ The premium used for this calculation was the premium for a 35 year old non-smoking male. Individual premiums may vary somewhat from this standard. Moreover, this calculation did not take subsidy programs into account so it may understate the affordability of the pool in states where such subsidies are available.

If we use 10 percent of family income as an operational cut-off of affordability, then insurance via the pool was affordable for these people, implying that the barrier to joining the pool was either a lack of awareness or a willingness to remain uninsured rather than pay premiums, perhaps with the expectation that insurance from another source would ultimately be available.

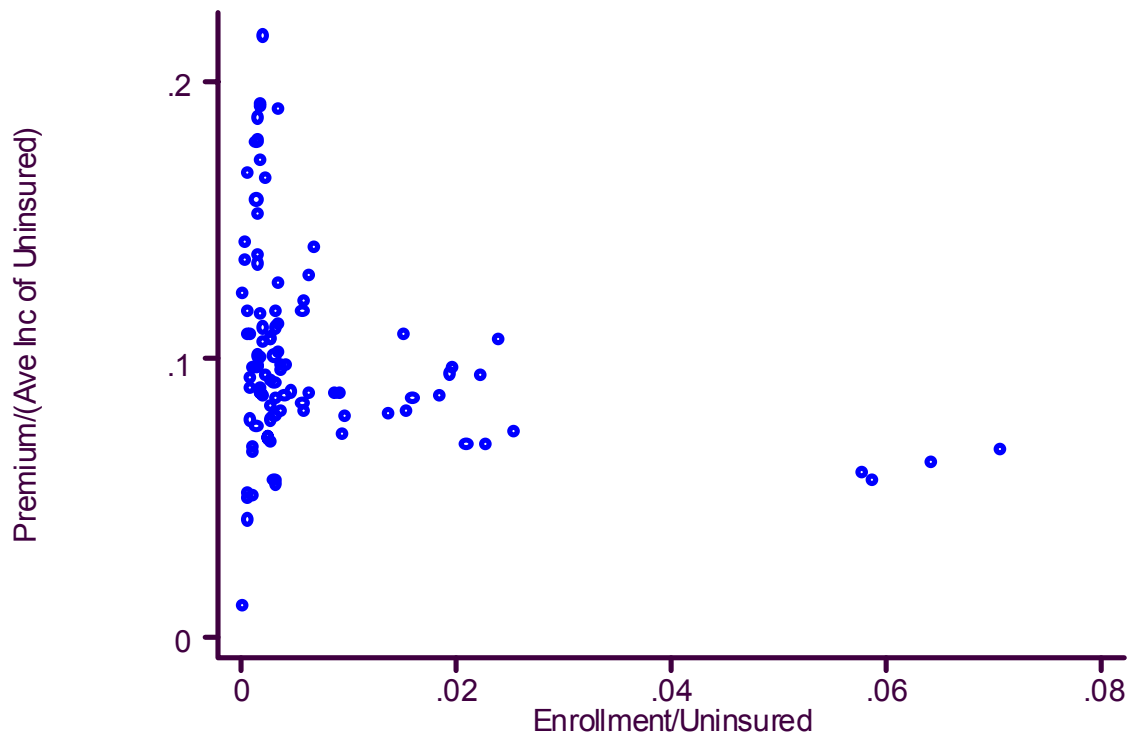
However, for 9 percent of individuals, 16 percent of uninsured individuals, and 27 percent of uninsurable individuals across the focus states, this same premium represented more than 25 percent of family income. It seems reasonable to say that insurance from the pool was not affordable for these people and that, practically speaking, the pools did not offer them access to health insurance.

7.4. Relationship between Enrollment and Affordability

In principle, one way to improve the access to health insurance that is provided by high-risk pools and to increase enrollment in the pools is to reduce premiums. The evidence suggests a strong relationship between premium levels and pool enrollment. This relationship is illustrated in Figure 7.3 which plots high-risk pool enrollment (as a fraction of the uninsured population) versus average high-risk pool premium (as a fraction of the average income of the uninsured population).

Figure 7.3

Affordability vs. Enrollment



Sources: U.S. Census Bureau, Current Population Survey, March 1998, 1999, 2000; Communicating for Agriculture Inc., "Comprehensive Health Insurance for High-Risk Individuals," 2000.

Each point in Figure 7.3 represents the high-risk pool in a different state. Aside from the large cluster of states around zero on the horizontal axis (i.e., those that enroll a vanishingly small proportion of the uninsured relative to the scale of the plot), a negative relationship between premium level and enrollment is evident. That is, as premiums go down (relative to income), enrollment goes up (relative to the uninsured population).

Multivariate regression analyses confirm this relationship. This type of analysis controls for state-level factors that may influence both premiums and enrollment. Total pool enrollment in a given state was modeled as a function of benefits, deductibles, and premiums (although the benefits variables were ultimately excluded due to concerns about over-fitting). The number of uninsured in the state and the mean family income for the uninsured were included as additional controls.

In order to insure that our findings were robust, we estimated four specifications for these analyses:

1. Specification 1 included all the states that reported individual premium data in all years that they reported it. The specification also included state-level fixed effects to control for permanent differences among states. Ergo, the elasticity estimate is based on how enrollment changes when premiums change over time, controlling for the initial level of enrollment within the state.
2. Specification 2 used data from 1999 only and included all the states that reported premium data in that year (the focus states). It had no fixed effects. This elasticity estimate is based on how enrollment rates varied among states in relationship to how premiums varied among states.
3. Specification 3 had the same structure as Specification 1 except that instead of using individual premium data, the specification used a proxy for premiums: the premium as a percent of the market rate and Medicare expenditure per Medicare beneficiary (a proxy for the market rate). This enabled us to use a larger number of states in the regression.
4. Specification 4 had the same structure as specification 2 except that, like Specification 3, it used premiums as a percent of market rate and Medicare expenditures per Medicare beneficiary to proxy for premiums.

Regardless, of specification, the estimated elasticity of pool enrollment with respect to premium was consistently statistically significant and large (greater than one). (See Table 7.5.) Elasticities with a magnitude greater than one indicate that a given percentage change in premiums would lead to a greater percentage change in enrollments, for example a ten percent drop in premiums would lead to at least a ten percent increase in enrollment.

This was true both when premiums were entered directly and when premiums were represented by the relationship between the pool premium and the market average premium combined with a proxy for the market average premium. This was true in both a single year cross section and in a multi-year panel with state fixed effects. Estimated elasticities ranged from 1.04 to 2.17, all with relatively large standard errors (.62 to 1.22). Thus, one can have confidence in the general finding of a large elasticity and a significant relationship although one cannot be sure of the exact magnitude.

Table 7.5**Estimated elasticities of enrollment with respect to premiums**

Specifications based on reported premiums		
Spec 1: State Effects	N=53	1.04* (.62)
Spec 2: Single Year (1999)	N=15	1.97** (.80)
Specifications based on premium as a percent of market premium		
Spec 3: State Effects	N=144	1.35** (.63)
Spec 4: Single Year (1999)	N=24	2.17* (1.22)

Specifications 1 and 2 based on all states reporting premium data (15 states in 1999; see above).

Specifications 1 and 3 included all years available 1994-1999 and state effects.

Specifications 2 and 4 use 1999 data only.

Specifications 3 and 4 based on premium as percent of market when available and statutory cap otherwise; every risk pool state except Kansas reported the latter number. These regressions included a control for Medicare spending per Medicare beneficiary, intended as a proxy for state-by-state variations in medical expenditure and consequently as a proxy for the market premium.

All regressions included controls for the deductible associated with the lowest deductible plan, whether or not additional plans were available the number of unemployed in the state, and the mean per capita income of the unemployed. Regressions with state effects also included a control for the year.

*Standard errors in parentheses; * and ** indicate significantly different from zero at the 10 and 5 percent confidence levels, respectively.*

State-level results are included in Appendix F.

Sources: Abt Associates using data from Communicating for Agriculture, the CPS, Statistical Abstract.

The question becomes, “How do these elasticities translate into impacts on enrollment under reasonable policy scenarios?” Table 7.6 presents the simulated enrollment impacts of 1) cutting monthly premiums to \$118 in all states and 2) setting premiums at 125 percent of market in all states. These numbers were selected because they match the lowest premium numbers observed in the data (both occur in Minnesota) and hence represent a plausible floor for premium levels. Because the elasticities are imprecisely measured and because the simulations probably oversimplify the relationship under study, they should be interpreted as suggesting general ranges for the potential impacts rather than exact forecasts.

Based on these simulations, lowering the premium to \$118 in all 15 focus states would approximately double or triple pool enrollment. However, note that even with premium cuts, pool enrollment remains a low fraction of total population, less than one-quarter of one percent, based on either Specification 1 or 2. This estimate is consistent with the fact that pool enrollment in Minnesota was one half of one percent of total population. The increases in enrollment estimated as a result of this policy change would represent 0.3 to 0.8 percent of the uninsured population and 5 to 16 percent of the uninsurable populations.

The simulations also indicate that capping all premiums at 125 percent of market would lead to about a 20 to 35 percent increase in pool enrollment. Again, this relatively large proportion increase in enrollment represents only a small fraction of the overall uninsured or uninsurable populations, although the availability of the pool may be very significant in the lives of the people who do enroll. Note also that cutting premiums in order to raise enrollment has a dramatic impact on deficits. In these simulations, the marginal deficit per marginal enrollee ranged from \$4,700 to \$6,100. (This

number is higher than the per enrollee deficit because cutting premiums reduces per capita revenue and raises per capita deficits for all enrollees in the pool not just the marginal enrollees.)

Table 7.6
Enrollment and Deficits Associated with Premium Reductions

	States with premium data N=15			All states with pools N=24		
	Actual	Simulation: 118 premium		Actual	Simulation: 125 percent	
		Spec 1	Spec 2		Spec 3	Spec 4
Enrollment	75,000	126,000	222,000	102,000	120,000	136,000
Total population	100 M	100 M	100 M	149 M	149 M	149 M
Total enrolled as pct of population	.07%	.13%	.22%	.07%	.08%	.09%
Marginal enrollment due to		52,000	148,000		18,000	34,000
Total uninsured population	18.5 M	18.5 M	18.5 M	25.6 M	25.6 M	25.6 M
Marginal enrolled as pct of uninsured		.3%	.8%		.07%	.14%
Total "uninsurable"	1.0 M	1.0 M	1.0 M	1.4 M	1.4 M	1.4 M
Marginal enrolled as pct of		5.4%	15.5%		1.2%	2.4%
Total deficit	\$211M	\$526M	\$996M	\$296M	\$391M	\$455M
Marginal deficit		\$315M	\$785M		\$95M	\$159M
Marginal deficit / marginal enrollees		\$6,058	\$5,304		\$5,278	\$4,676

Specifications 1 and 2 based on all states reporting premium data (15 states in 1999; see above).

Specifications 1 and 3 included all years available 1994-1999 and state effects.

Specifications 2 and 4 use 1999 data only.

Specifications 3 and 4 based on "premium as percent of market" when available and statutory cap otherwise; every risk pool state except Kansas reported the latter number. These regressions included a control for Medicare spending per Medicare beneficiary, intended as a proxy for state-by-state variations in medical expenditure and consequently as a proxy for the market premium.

All regressions included controls for the deductible associated with the lowest deductible plan, whether or not additional plans were available the number of unemployed in the state, and the mean per capita income of the unemployed. Regressions with state effects also included a control for the year.

Deficits are calculated as claims plus administrative costs less per capita revenue. In simulations, per capita revenue is assumed to fall in proportion to the change in premium or premium-as-percent-of-market-premium..

Sources: Abt Associates using data from Communicating for Agriculture, the CPS, Statistical Abstract.

7.5. Pool Financing

As has been presented, high-risk pool enrollment is growing but is still low relative to the size of the uninsured or uninsurable population. We have shown the extent to which enrollment might increase if premiums were reduced. However, as has also been discussed, even at existing levels, premium revenue does not cover high-risk pool expenses. High-risk pools run deficits that are financed by state or industry funds. A further reduction in premiums without a new source of financing would increase reliance on deficit funds and would, undoubtedly, present political and fiscal challenges in most states.

This section takes a closer look at high-risk pool financing. Revenue, expenses, and deficits are tracked across time to show how pool financing has changed and to suggest what the future might hold if recent trends continue. We also comment on differences between HIPAA and non-HIPAA pool states. We begin with an examination of claims.

Not surprisingly, per enrollee annual dollar amount in claims is relatively high for high-risk pools. Some pool directors have speculated that this cost is higher for HIPAA eligibles as compared to non-HIPAA eligibles. While the available data do not permit precisely this comparison, Table 7.7 is a first step. It shows per enrollee claims by state for both HIPAA and non-HIPAA pool states in 1998 and 1999 as well as national averages for these two types of states in both years.

Table 7.7

Per enrollee claims by state for HIPAA and non-HIPAA pools in 1998 and 1999 (in 2000 dollars)

<i>HIPAA pool state</i>	<i>non-HIPAA pool state</i>	<i>1998</i>	<i>1999</i>
Alabama		\$155.03 ^a	\$4,299.74
Alaska		\$8,847.65	\$9,817.96
Arkansas		\$2,741.94	\$3,450.56
	California	\$4,536.13	\$4,991.84
	Colorado	\$6,275.81	\$4,298.10
Connecticut		\$11,000.00	\$7,010.43
	Florida	\$8,848.46	\$7,826.44
Illinois		\$7,178.78	\$7,410.74
Indiana		\$10,194.87	\$8,996.23
Iowa		\$7,083.75	\$10,731.89
Kansas		\$5,566.75	\$5,672.81

Table 7.7

Per enrollee claims by state for HIPAA and non-HIPAA pools in 1998 and 1999 (in 2000 dollars)

<i>HIPAA pool state</i>	<i>non-HIPAA pool state</i>	<i>1998</i>	<i>1999</i>
Louisiana		\$6,690.66	\$7,370.11
Minnesota		\$3,867.12	\$4,167.81
Mississippi		\$4,804.29	\$4,240.67
	Missouri	\$8,093.67	\$9,551.95
Montana		\$3,312.18	\$4,657.18
Nebraska		\$5,368.20	\$5,372.88
New Mexico		\$5,271.25	\$6,099.05
North Dakota		\$3,794.54	\$4,381.40
Oklahoma		\$3,941.65	\$8,343.34
Oregon		\$4,875.72	\$3,881.83
South Carolina		\$7,715.13	\$7,140.69
Texas		\$3,370.30	\$5,960.96
Utah		\$4,938.09	\$5,211.60
	Washington	\$8,325.79	\$9,259.18
Wisconsin		\$5,391.16	\$4,251.01
Wyoming		\$4,788.73	\$4,560.75
HIPAA AVERAGE		\$5,163.54	\$5,277.44
NON-HIPAA AVERAGE		\$5,036.95	\$5,384.07

^a The Alabama pool began operation in 1998 and enrollment was relatively low that year as compared to subsequent years. Therefore, this per enrollee claims figure is not representative.

Sources: *Communicating for Agriculture Inc.*, "Comprehensive Health Insurance for High-Risk Individuals," 2000.

As can be seen from Table 7.7, the evidence that HIPAA eligibles are more expensive is mixed. While per enrollee claims were higher on average for HIPAA states relative to non-HIPAA states in 1998 (\$5,164 vs. \$5,036), the reverse was true in 1999 (\$5,277 vs. \$5,384). Because we cannot

separate HIPAA eligibles from non-HIPAA eligibles we cannot rule out the possibility that HIPAA eligibles are indeed more costly. It may be that non-HIPAA eligibles in HIPAA pool states pull down the per enrollee average claims.

Another interesting phenomenon is evident in Table 7.7. Per enrollee claims vary considerably, both geographically and temporally. For example, in 1998 Arkansas per enrollee claims were \$2,742 while Connecticut per enrollee claims were \$11,000. This geographical variation can be attributed to several factors including variation in the cost of care, variation in patterns of care, and variation in enrollee mix due to insurance market differences. Connecticut also provides a good example of large temporal changes. While per enrollee claims were \$11,000 in Connecticut in 1998, they were \$7,010 in 1999 (all dollar amounts are in constant 2000 dollars). This type of temporal variation might be due to changes in enrollee mix due to changes in the insurance market. For smaller pools, a few very large claims (e.g., transplants) can dominate the per enrollee average and account for an unusually high value in a single year.

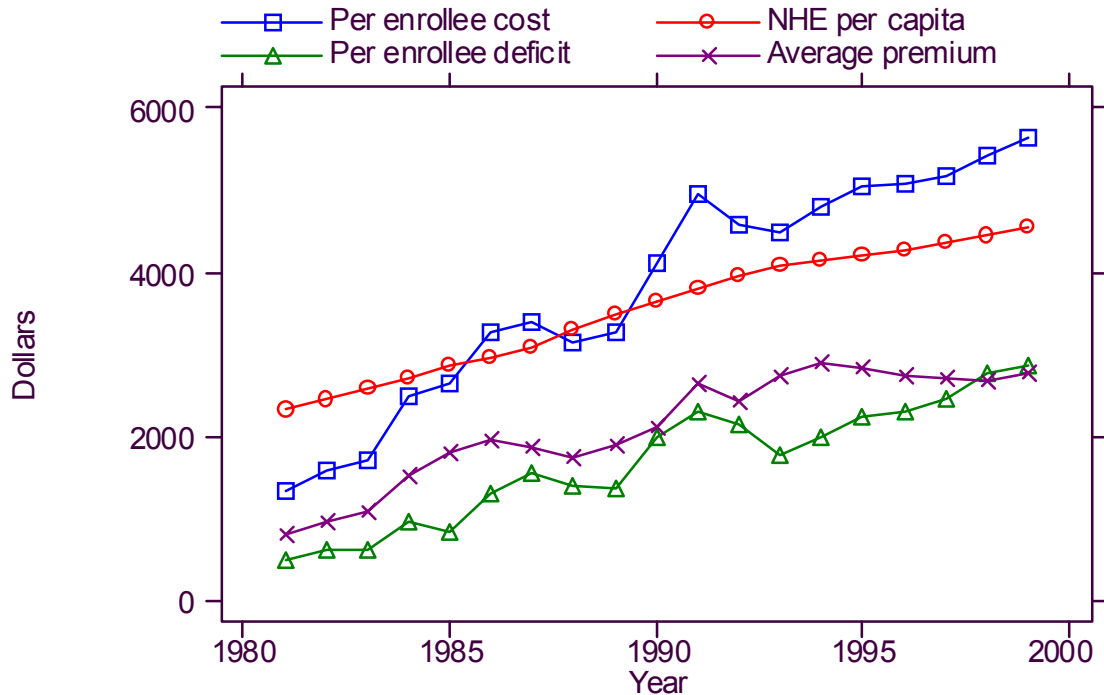
Finally, for both HIPAA pool states and non-HIPAA pool states, average per enrollee claims increased from 1998 to 1999. This may be due to an overall increase in the cost of care beyond the rate of inflation. It may also be due to an overall change in enrollment mix with relatively healthier individuals opting not to enroll in high-risk pools (perhaps in response to higher premiums), thus leaving the pools to care for relatively less healthy and more expensive individuals. Another possibility is changes in provided benefits. If benefits were more generous in 1999 as compared to 1998, claims would be expected to rise.

High-risk pool claims are partially funded by collected premiums. Since premiums are capped at below actuarially fair rates, each high-risk pool operates with a deficit, which is covered by state or insurance industry funds (or a combination thereof), as discussed previously. That is, collected premiums do not cover the cost of claims and administration. The average national deficit per enrollee has been increasing rapidly, tripling in real terms between 1985 and 1999. This increase might reflect a variety of factors including the real increase in cost of care or a change in pool enrollee mix toward less healthy individuals. It might also reflect a deliberate (and if true, apparently successful) attempt to keep high-risk pool premiums from increasing at the prevailing market rate in order to increase affordability and mitigate adverse selection.

Per enrollee deficit, together with average premium, comprise total per enrollee cost (put another way: whatever costs not covered by premiums is considered deficit). Figure 7.4 illustrates the historical trend in real per enrollee costs, premiums, and deficits, putting them in perspective relative to the trend in real per capita national health expenditures (NHE). As can be seen from Figure 7.4, per enrollee costs for high-risk pools has increased more rapidly than per capita NHE. This is not surprising since the pools consist of the most costly while NHE includes many who account for little health expenditure. It is somewhat surprising that per enrollee pool cost is lower than per capita NHE prior to the 1990s. However, the two are not directly comparable since the pool cost figure does not include out-of-pocket spending and the two statistics are computed for very different populations.

Notice from Figure 7.4 that until 1994, premiums and deficit were nearly parallel. After 1994, premium revenue has been declining while deficit funding has been growing. This suggests an

increasing burden on deficit funding mechanisms and is a potential threat to long-term pool stability. We have checked many individual states to verify that this is not due to outliers. The trends suggested by the figure are pervasive. It should be noted, however, that pool financial data have some limitations due to the fact that they are self-reported and inconsistent with each other. In particular, low-income premium subsidy dollars are not necessarily reflected in the premium data available to us (e.g., in Wisconsin they are not). Also, depending on how the pool's deficit is financed, some of these subsidy dollars may show up in the reporting of industry assessments. (If the subsidy is fully or partially funded through assessments, this is reflected in the assessment data.)

Figure 7.4**National per enrollee deficit^a by year (in 2000 dollars)**

^a Deficit is defined as claims and administration costs, less collected premiums.

Sources: Communicating for Agriculture Inc., "Comprehensive Health Insurance for High-Risk Individuals," 2000.

Fundamentally, data quality is not high enough to make unambiguous statements regarding high-risk pool financing. Nevertheless, the real increase in per enrollee deficits indicated in Figure 7.4 is cause for concern. If it continues, deficit funding sources (e.g., health insurance carriers and state revenue) may be severely stressed, potentially leading to enrollment caps and/or large premium increases. Another way of viewing deficit increases is illustrated in Table 7.8, which reports the distribution of deficits as a percentage of collected premiums in 1994 and in 1999 (with one observation per state per year). In both years, the median deficit was over 50% of collected premiums (59% in 1994 and 85% in 1999). The large real increase in deficit in 1999 relative to 1994 is evident at all percentiles of the distributions. This indicates that deficit growth is outpacing premium growth within high-risk pools and, since pool premiums are based on private market premiums, pool deficits are growing faster than private market premiums as well. Furthermore, the distributions in Table 7.8 show that the increase is not due to a few outliers but is broadly based. Indeed, every high-risk pool has experienced increases in per enrollee deficit.

Table 7.8**Distribution of deficit as percent of collected premiums in 1994 and 1999**

<i>Percentile</i>	<i>Deficit as percent of collected premiums^a</i>	
	<i>1994</i>	<i>1999</i>
5%	18%	45%
10%	22%	50%
25%	48%	66%
50%	59%	85%
75%	80%	135%
90%	119%	186%
95%	128%	229%

^a Deficit is defined as claims and administration costs, less collected premiums. There is one observation for each pool in each year.

Sources: *Communicating for Agriculture Inc.*, “*Comprehensive Health Insurance for High-Risk Individuals*,” 2000.

7.6. Conclusion

This chapter began with a state-level description of the uninsured population and the subset of uninsured who are uninsurable due to medical conditions. This provided a context for high-risk pools since they are designed to serve the uninsurable population. In particular high-risk pools offer health insurance to individuals who cannot purchase insurance in the individual market due to medical underwriting restrictions.

While high-risk pools are designed to serve the uninsurable population, only a small fraction of the uninsurable, 3.5% nationally, are enrolled in a high-risk pool. However, high-risk pool enrollment has been growing in recent years and the rate of growth has outpaced the rate of growth of the uninsured and uninsurable population. (The latter population has actually been shrinking in recent years.)

One barrier to high-risk pool enrollment, and hence growth, is affordability. High-risk pool premiums remain too high for many who are barred from purchasing an individual policy on the open market. Multivariate models presented in this chapter revealed that high-risk pool enrollment could certainly be increased via premium cuts but that the increase in enrollment would have a high price in terms of total and per capita deficits.

Reducing premiums is not easy, however. High-risk pools already run large deficits and the deficits have been growing (and growing at a rate faster than that of national health expenditures). This suggests that high-risk pools will have to rely more heavily on state and industry deficit funding in the future, even if enrollment increases at the current rate. Thus, while increasing the rate of enrollment (by lowering premiums) would accelerate the pace of reduction in the numbers of uninsurable and uninsured, it would not be easy to achieve politically. Indeed, maintaining the current trends in enrollment and deficit growth may not be sustainable. To combat growing deficits, high-risk pools may impose enrollment caps, premium increases, or some other cost containment measures. Of course, the former is not allowable under HIPAA, creating a potential confrontation between statutory requirement, financial resources, and political pressures.

Appendix A: State Summaries

Alabama

The Alabama Health Plan (AHIP) began operations in 1998 and was created solely to comply with HIPAA. Deficits are funded by carrier assessments with a 100% premium tax credit. Enrollment has been increasing rapidly with 841 enrollees in 1998, 1,773 in 1999, and 2,431 through June of 2000. As a result, total assessments are growing, reaching \$3.82 million in 1999.

Funding the pool is anticipated to become a difficult political issue in the near future. Since assessments are offset against taxes, the pool is essentially funded through general revenue (or, more precisely, through lost tax revenue). Total state tax revenue is dropping, however, making it more difficult for the state to forgo the premium tax revenue. Tax receipts are lower because most of the state's tax revenue is derived from the sales tax (income and property tax rates are extremely low) and consumer purchasing is declining due to cyclical factors.

Alaska

A consumer with a chronic health condition provided the impetus for Alaska to enact a high-risk pool in 1993. That consumer, who until last year still sat on the pool board, asked a legislator to introduce and pass the NAIC model legislation. Almost immediately, however, funding became a problem.

The pool was designed to be funded from an assessment on insurers. At the time the bill was enacted, Alaska had group coverage for state employees through Aetna. The insurance company was very concerned about a growing assessment and produced what pool officials say were flawed extrapolations about future pool costs. The legislature reacted by putting state employees in a self-funded plan, removing them from the assessment base. With this action, the assessment base was reduced by 40 percent.

The assessment includes stop-loss insurers, which are regulated like any other insurer in state statute. Premiums are capped at 200 percent of the standard market rate. In practice, premiums were set at about 175 percent of private market rates and have dropped over time to approximately 150 percent currently. Enrollment, which has grown steadily but slowly, recently experienced a significant jump, climbing 20 percent in one year.

The pool continues to be consumer driven. The board has a very active advertising committee that promotes outreach. In addition, consumers have recently raised the issue of providing a subsidy for low-income pool enrollees.

Arkansas

The Arkansas Comprehensive Health Insurance Plan (CHIP) was created in 1995 after failing to gain legislative approval in 1991 and 1993 because of the funding mechanism – an assessment without an

offset. The 1995 legislation that passed was based on the NAIC model – an assessment with a dollar-for-dollar tax credit. The assessment includes stop-loss insurers, based on the premium written.

Enrollment in the pool has grown rapidly, with approximately 150 new enrollees each month. As enrollment grows, losses are mounting and funding is becoming a bigger concern. The pool is funded one-third from assessments and two-thirds from premiums. Some of the larger carriers are able to offset their entire tax liability, so the Department of Insurance has started to consider a direct appropriation from the state general fund instead of an assessment with a tax credit.

The Board plans to ask the Legislature for an interim study of the pool's funding, for consideration in the next legislative session in 2003. Until then, the Board will consider raising rates every six months and asking the Legislature to reduce benefits in order to meet the mounting losses.

California

The California high-risk pool, known as the Managed Risk Medical Insurance Plan (MRMIP) is funded primarily by premiums and a limited stream of revenue from the Cigarette and Tobacco Surtax Fund (\$40 million per year since 1997). In 2000 MRMIP also received an additional \$5 million appropriation and a \$2 million grant. To avoid shortfalls, enrollment in the California pool is capped (at 19,815 in 2000 but expected to drop to 15,000) and the waiting list has grown quite large with 4,000 individuals, each expected to have to wait about one year. Despite the complete absence of marketing efforts, the waiting list is expected to continue at maximal levels for the foreseeable future.

To serve those on the waiting list, both Blue Cross of California and Blue Shield of California have offered, until recently, "look-alike" programs with coverage comparable to the high-risk pool at unsubsidized rates. About 80% of individuals on the waiting list for MRMIP purchased a look-alike policy. Recently, Blue Cross has changed the benefits package associated with these programs so they conform to its other products and not to MRMIP. The governor of California and the high-risk pool board have decided to address additional problems of access to health insurance and to satisfy HIPAA regulations through market reforms rather than through the high-risk pool. Given the lack of political support for additional funding for the high-risk pool in California, it is unlikely that California will seek to have its high-risk pool accepted as a state alternative mechanism.

Despite insurance market reforms and due to MRMIP's enrollment cap, California has a large uninsured population with 24% of residents lacking health insurance. An estimated 2.5% to 5% of this uninsured population is uninsurable due to medical conditions. This translates to as many as 123,000 individuals in the population potentially served by MRMIP. Other estimates have put the figure closer to 300,000.

Colorado

CoverColorado, formerly the Colorado Uninsurable Health Insurance Plan, began operation in 1990. Premiums are capped at 150 percent of the market rate and the plan offers three deductible levels -- \$300, \$750 and \$2,000. Enrollment is highest in the plan with the \$300 deductible.

Colorado is a federal fallback state. A pool representative said the state decided not to use the pool as its HIPAA alternative mechanism because the pro-consumer Insurance Commissioner believed doing so would relieve insurance companies of their responsibility. This may change, however. The state is currently considering legislation that would allow the pool to collect an assessment. The pool has struggled with funding from different sources – starting with a state appropriation and now using the interest from an unclaimed property fund – so the current legislation is an attempt to address that problem through a regular and more predictable source of funding. In return, the pool would become the HIPAA alternative.

This legislative proposal is part of a broader reform agenda that grew out of a recent six-month task force on health insurance in the state. Another legislative proposal that resulted from the task force would have made changes throughout the insurance market, affecting open enrollment, rating restrictions, provider networks, and “business groups of one.” Colorado allows “business groups of one” that capture self-employed individuals. There has been some discussion of using the pool for “business groups of one,” but consumer groups and small business representatives have opposed this because of the pool’s “stigma” as a government program.

Connecticut

Connecticut operates the oldest high-risk pool in the country. The Connecticut Health Reinsurance Association (HRA), which began operation in 1976, is funded from an assessment on insurers. HMOs were not originally part of the assessment base but were added in 1994 when HRA began offering managed care plans to enrollees. The state also tried to assess some of the smaller self-insured plans in the early 1980s, but SAFECO objected, the board relented, and the assessment has never been implemented because the board doesn’t think it could withstand a legal challenge.

In 1997, Connecticut had a very high loss ratio because of abnormally low premiums collected (half the amount collected in the prior and succeeding years). This was a result of changes in the small group market, upon which HRA bases its standard market rate. In 1996 and 1997, there were many new arrivals to the small group market, so the carriers reduced their prices to be competitive. As a result, the pool’s premium rates – as a function of the small group market rates - dropped as well.

In 1990, a Blue Ribbon Commission made a number of recommendations that were adopted, including guaranteed issue for small groups down to one, a small employer program that used HRA as a reinsurer, and the Special Health Care Plan (SHCP), a subsidy program for low income enrollees in the pool. SHCP was designed for families with incomes up to 200 percent of the federal poverty level.

SHCP offers lower deductible levels than the other HRA plans (\$200 for individuals and \$400 for families, compared to \$2,500 for individuals and \$5,000 for families in the HMO or PPO in-network plans). Also, SHCP reimburses enrollees for 75 percent of the cost of care once they have met the deductible; HMO coverage usually requires a \$10 co-pay and the PPO in-network coverage reimburses 80 percent of costs. The other major difference is that SHCP does not cover prescription

drugs. This coverage difference helps prevent SHCP from becoming an attractive alternative to qualifying individuals who would otherwise obtain insurance from the private market.

Pool staff have expressed an interest in finding a way to use SHCP and HRA to help low-income workers buy employer-sponsored coverage. Their goal is to assist those people who are still working and have coverage available to them, but cannot afford their share of the premium.

Florida

The Florida Comprehensive Health Association (FCHA) began in 1983 as the State Comprehensive Health Association. Enrollment in the pool was slow until the late 1980s when it began to grow quickly, prompted in part by a Department of Insurance rule requiring insurers to notify people turned down for insurance about the existence of the pool. The pool was funded by an assessment with an offset, until 1989 when the tax credit was eliminated because of state budget problems.

During this time, the pool's costs were growing while the rates stayed about the same, resulting in rapidly increasing losses for the pool. In 1990, the year after the tax credit was eliminated, the assessment nearly doubled to more than \$33 million. The insurance industry balked but advocates protested, so legislation was passed to reorganize the pool with managed care options, rename it as FCHA, and close the pool to new enrollment. The board also changed from a nine-member board with an industry majority to the current three member board, made up of the Insurance Commissioner, a policy holder and an industry representative.

With this change, premiums were increased from 150 percent of the standard market rate to up to 250 percent for high-risk individuals (based on underwriting). Enrollees' rates could be adjusted down annually through an appeals process, to 225 percent for medium-risk and to 200 percent for low-risk. Enrollment dropped drastically over the last decade, from a high of 7500 in 1990 to just 800 in 1999.

There have been attempts to reopen the pool, including an unsuccessful legislative proposal last year to shift the funding from an assessment to an endowment made up of either general revenue or tobacco settlement money. The Commissioner of Insurance has submitted a legislative proposal for consideration this session to fund the pool from a surcharge on insurance policies, including those issued by stop-loss insurers. The surcharge would be \$1 per enrollee per month. The proposal would also reconstitute the board and open the pool to HIPAA eligibles. An industry representative said they would support reopening the pool if the funding mechanism is broad-based rather than an assessment, which can reach only one-third of the plans in Florida because of ERISA exemptions.

Illinois

The Illinois Comprehensive Health Insurance Plan (ICHIP) commenced operation in 1989. In 1997, a separate pool was created for HIPAA-eligible individuals. Deficits incurred by the two pools are funded differently. The original, non-HIPAA pool funds deficits from general revenue while the HIPAA pool does so by assessing all health insurance carriers licensed in the state. Corresponding to the different funding mechanisms, enrollment in the two pools is handled differently. The non-

HIPAA pool has a statutory cap commensurate with its funding. The HIPAA pool has no enrollment cap and is growing rapidly with about 200 new members per month.

The enrollment cap for the non-HIPAA pool is rarely imposed. Until recently, enrollment had not reached the cap since 1994. In 2000, a cap was imposed because claims exceed projections by \$10 million due, it is thought, to escalating health care costs.

Indiana

The Indiana Comprehensive Health Insurance Association (ICHIA) began operating in 1982 and it is now used as the state's HIPAA alternative mechanism. Enrollment growth slowed in the early- to mid-1990s perhaps due to a large increase in premiums in 1989. This increase in premiums ultimately led to a lawsuit in which the plan was accused of charging illegal rates. The lawsuit was settled in late 1990 with new premium rates and rebate checks were distributed to enrollees. Nevertheless, one interviewee believed that this premium volatility had a downward effect on enrollment into the 1990s.

Recently, enrollment has grown rapidly for two reasons. First, the state now pays the ICHIA premiums for HIV patients. This increased enrollment by 1,300 individuals. Second, there have been numerous small group withdrawals in the state in 2000. Enrollment has increased from 4,513 at the end of 1999 to 6,475 at the end of 2000. This rapid enrollment growth is stressing funding (pool deficits are funded by assessments with a premium tax credit), although there are no plans to change the funding mechanism.

Iowa

Iowa operates two different pools: a high-risk pool that is used for HIPAA compliance and a reinsurance pool. The two pools differ in many ways, including their rating restrictions, funding mechanisms, eligibility requirements, member insurers, and even the reasons for which they were developed.

The high-risk pool used for HIPAA compliance is known as the Iowa Comprehensive Health Association (ICHA) and was established in 1987 as a social program intended to protect a population who couldn't get insurance. The pool hires an administrator, sets premiums at no more than 150 percent of the standard market rate, and funds deficits through an assessment that can be offset with credits spread out over five years. Enrollment peaked at 2,100 in 1992 and has slowly dropped to just 300 enrollees currently. Officials attribute this decline, in part, to the creation of an alternative source of insurance for some of the uninsurable – the reinsurance plan.

The Iowa Individual Health Reinsurance Association (IHRA) was enacted in 1994 and began operation in 1996. When the state began considering guaranteed issue, there was a concern that insurers would leave the market, so the state decided to replace the conversion process with a privatized risk pool. There is no administrator for the reinsurance pool. Instead, the pool is administered by the companies themselves, which must sell a standard ("high") and basic ("low") plan. Rates are set relative to a company's lowest priced product using a factor set in statute,

amounting to roughly two times the lowest priced product. Companies' losses are equalized through an assessment established by the IHRA board.

Eligibility requirements also differ for the two pools. The high-risk pool serves people without any coverage and HIPAA-eligibles. The reinsurance pool requires prior group coverage for at least 12 months, or an offer of coverage at rates that exceed certain rates established by the pool. HIPAA eligibles could actually qualify for either pool, but state officials believe most would go to the reinsurance pool because the rates are usually lower (and in fact, high-risk pool officials believe the 300 who remain in their pool are the most costly).

The funding mechanisms are also different. The high-risk pool assesses any company selling insurance in Iowa. The reinsurance pool assesses the same companies, plus government entities with self-funded plans (generally municipalities) and self-funded companies that opt into the pool. (A company would opt in so its retirees could obtain coverage through the pool.)

There have been discussions about merging the two pools, although the different funding mechanisms are a major obstacle. With the high-risk pool offering an offset for the assessment, any proposal to merge the pools must address the issue of whether and how general revenue will be affected.

Kansas

The Kansas Uninsurable Health Insurance Plan was started in 1993 with a \$2 million loan from the state. The first assessment was levied in 1995. The original legislation, enacted in 1992, prohibited offsets for the first four years, but beginning in 1996 insurers could obtain a partial credit for their assessment. In 1996 insurers could offset 80 percent of their assessment, but by statute that amount has been reduced over time to 60 percent credit.

The Insurance Commissioner plays a relatively active role in the Kansas pool. Premiums are allowed by statute to be as high as 150 percent of the standard market rate, but the Commissioner, who must approve the rate recommended by the board, has said she wants to keep the premiums lower. The current premium rate is approximately 138 percent. Also, the statute does not require the 11-member board to have consumer representatives, but the Commissioner has historically recommended five "consumer" representatives (including a parent, a retiree, two agents and a consultant for a health care data company).

The Kansas Legislature decided to use the pool as its HIPAA alternative mechanism and made changes in the pool to comply with the federal law. The pool increased the number of plans offered from two to five and increased the lifetime benefit maximum. At the same time, the state enacted small group reforms that reduced the pre-existing condition (PEC) exclusion period from six months to 90 days. Since then, the pool has seen an increase in maternity claims. They are currently conducting an analysis to see if the increase in these claims is related to the shortened PEC exclusion, and may go to the Legislature to request a change in coverage.

Louisiana

Louisiana operates two pools: a non-HIPAA pool that is funded from state appropriations and a surcharge on hospital admissions, and a HIPAA pool that is funded from an assessment on insurers. Only the HIPAA pool is accepting new enrollees at this time.

The pool, known as the Louisiana Health Plan, was established in 1990. From the beginning, funding has been a problem. Legislation enacted in 1991 provided for a standard annual appropriation, but the statute was repealed the following year. Since then, the pool has had to request funding from the legislature each year and there is no guarantee of funding. Another funding mechanism established in 1990 placed a \$2 per day surcharge on hospital admissions. However, the surcharge cannot be applied to government or public programs, including state employees' plans, Medicare or Medicaid, nor can it be applied to self-funded plans. Pool officials estimate 60 percent of hospital admissions are "truly uncollectable."

The state legislature decided to use the pool for HIPAA compliance. To do so, they had to revisit the benefit structure and eligibility for the pool, as well as the funding, so it was "like starting from scratch." The state decided to fund the HIPAA pool from an assessment on all insurers based on their premium share in the market. There have been efforts to expand the assessment base, including an unsuccessful attempt last year to assess bail bonds, one of a few insurance products that doesn't currently pay any assessments.

The Department of Insurance would like the non-HIPAA pool to move to an assessment with an expanded base that includes stop-loss insurers. There is currently a work group looking at this issue, with the insurance industry involved in the discussions.

Minnesota

Minnesota operates one of the oldest, largest, most affordable, and most efficient high-risk pools in the country. The Minnesota Comprehensive Health Association (MCHA), as it is called, was created in 1976 and became operational the following year. As of June, 2000 MCHA had over 25,000 enrollees. Its popularity is due, in part, to its affordability; its premium cap is among the lowest in the nation (121% of individual market rates for the general pool and 125% for the Medicare supplement). Nevertheless, the state is considering a subsidy program to assist those who cannot afford the MCHA premium. Finally, MCHA per enrollee administrative costs are generally below the national average.

MCHA has received funding from a variety of sources. During its first two years of operation, MCHA was funded through assessments of all health insurance plans with a 100% premium tax credit. In 1979 only the indemnity insurance carriers were required to pay the assessment. In 1987 HMOs, PPOs, fraternal organizations, and nonprofit health service plan corporations were again obligated to pay the assessment. Also that year the tax credit was revoked. In 1997 the Minnesota Legislature appropriated \$15 million for each of the next two years to MCHA to help offset deficits. These funds came out of the state's "Health Care Access Fund" which had been funded through a 2% provider tax and was reduced to 1.5% in 1997. This tax is paid by providers and hospitals and passed on to insurance purchasers, including self-insured purchasers, and has withstood an ERISA challenge.

In 2000 the Minnesota Legislature appropriated \$15 million to MCHA out of a surplus in the Minnesota's Workers Compensation Assigned Risk Plan. This funding mechanism has been challenged as unconstitutional and the case is still pending.

Despite the large variety of funding sources, the growth of self-insured plans (now about 50% of all benefit plans) will likely make sustainable funding difficult as well as future ERISA challenges more likely. Indeed, the state itself is now self-funding health care for state employees. In addition to the worrisome precedent this sets, this presents a large financial problem for the pool. It also presents conflict of interest issues as the state attempts to collect funds from self-insured entities.

While MCHA is the state's HIPAA alternative, HIPAA had little impact because Minnesota enacted portability insurance reforms before HIPAA. Even without special provisions for HIPAA eligibles, most would be enrolled in MCHA anyway because there are many waiting period exceptions. On the other hand, small group reforms in the mid-1990s (i.e., guaranteed issue, limits on conversion policy rates) did have an impact on the number of MCHA enrollees but not a substantial impact on claims.

Mississippi

The Mississippi Comprehensive Health Insurance Risk Pool Association began operating on a trial basis in 1992. The program was permanently extended in 1997 when the state decided to use the pool as the HIPAA alternative mechanism. The statute that establishes the pool only broadly defines the program and authorizes the board to determine how the pool operates, through board enacted and amended bylaws and operating rules. For example, the board has authority to determine benefits, deductibles, residency requirements and pre-existing condition exclusion periods.

Pool rates are set in statute at between 150 and 175 percent of the standard market rate. To date, the board has tried to keep the rates close to the statutory minimum. The pool's executive director has said he believes the *stability* of price is more important to consumers than the price itself. Also, beginning January 1, 2001, the board raised deductible levels for new enrollees.

There is no cap on enrollment, but this is contingent on available funding. The pool actuary estimates the number of enrollees that can be accommodated with available funding (currently estimated at 2800 to 3000 enrollees, with actual enrollment at about 2,500). If the actuary were to advise the board that enrollment is approaching the maximum number of enrollees, the pool would institute a waiting list for non-HIPAA enrollees.

The pool is funded from an assessment on all insurers at the rate of \$1 per covered person per month. The assessment includes stop-loss insurers, but the state uses an "honor system" in which stop-loss insurers are asked to report how much they owe. The intent of the assessment is to charge each covered life just once, so that stop-loss insurers do not owe an assessment for people already included in the primary insurer's assessment. The state is currently developing a survey process for obtaining information about stop-loss insurers and the number of lives they cover.

The board decided more than a year ago that they would be willing to litigate the state's authority to assess stop-loss plans, believing they can defend the practice based on statute, case law, and even the

intent of HIPAA. Since self-funded plans cover many of the insured, some of whom may one day require coverage through a HIPAA pool, the pool board believes it is both appropriate and defensible to include stop-loss insurers in the pool's assessment base.

Finally, Mississippi is the only pool that requires individuals to enroll through an agent. The pool requires this because most enrollees learn about the pool through an agent anyway, and there was an expectation that applications that are received from an agent will be more complete and require less administrative time. However, exceptions have been made for individuals with valid concerns about confidentiality.

Missouri

The Missouri Health Insurance Pool began operation in 1991. Premiums can go no higher than 200 percent of the standard market rate and deficits are funded by an assessment with a full offset against premium taxes. Enrollment in the pool peaked at 1,100 people in 1995 and has been declining ever since. Pool officials attribute this decline to the high cost of pool coverage, estimating that most people in the pool are relatively wealthy early retirees not yet eligible for Medicare or those who have a provider or benefactor paying their premiums.

In order to promote enrollment, the board is taking a number of steps. Rates were frozen for the last two years, effectively dropping the premium as a percent of the market rate from 200 percent to 183 percent. However, the board does not want the premium to drop below 175 percent. In addition, the pool is adding two higher-deductible plans and will implement an agent's fee to promote enrollment.

The board's concern with the high cost of coverage is shared by others. There is regularly a proposal in the legislature to lower the premium cap to between 130 and 175 percent. This year's proposal would lower the premium to 150 percent, but a state budget shortfall means that any proposal that would reduce revenues or increase spending will face stiff resistance.

Cost and its impact on enrollment are also reasons why the pool was not used for HIPAA compliance in Missouri. The state decided not to use the pool because the Department of Insurance believed it wasn't an effective mechanism, citing the pool's high cost and low enrollment since its inception. Missouri is instead a federal fallback state.

Montana

The Montana Comprehensive Health Association (MCHA) began issuing policies in 1987. With the exception of the years 1992-1995, the number of enrollees has grown each year, reaching 1,687 in June of 2000. The slight enrollment drop in the years 1992-1995 was due, perhaps, to small group reforms. In response to HIPAA, in 1997 a separate pool was created as the state's HIPAA alternative. While both the HIPAA and non-HIPAA pools are growing in size, the former has been growing much more rapidly in the past several years.

MCHA deficits are funded through assessments on licensed carriers in proportion to received premiums. These assessments are offset against premium taxes. To augment this revenue, the board

is giving some consideration to seeking additional funding from grants or the tobacco settlement. In fact, use of tobacco settlement money has been authorized but it has not yet been needed.

Nebraska

The Nebraska Comprehensive Health Insurance Pool (CHIP) began operations in 1986. It now acts as the state's HIPAA alternative mechanism. Enrollment has consistently grown since the pool's inception and has been about 300 members per year in recent years. Corresponding to enrollment growth, assessments to members have also grown.

Two significant changes are being implemented in 2001. First, the funding mechanism is changing so that pool deficits will be explicitly funded from general revenue (from premium tax revenue). Prior to 2001, pool deficits were implicitly funded from general revenue through assessments with a premium tax credit. Insurance carriers objected to this mechanism for two reasons: (1) often they could not recover the full assessment because the tax credit was non-refundable and (2) they were required to claim the credit over a five year period, not all at once.

The second significant change is to the structure of the board. The number of board members is being reduced to 7 from 9 and will include a policy holder. The previous board composition did not necessarily include a policy holder.

New Mexico

The New Mexico Comprehensive Health Insurance Pool (NMCHIP) began in 1988. In 1994 a low-income subsidy program was introduced. Individuals qualify for discounted premiums on a sliding scale basis, with the discount ranging from 25 to 5 percent for incomes between 100 and 200 percent of the federal poverty level. Seventeen percent of the pool enrollees receive a subsidy. The subsidy is considered inadequate by many (including the NMCHIP's board chair) and there is interest in increasing its generosity. The pool is the state's HIPAA alternative.

Generally the pool has been stable. Some legislation has affected enrollment over the years. For example, in 1994 the legislature passed the New Mexico Health Alliance which established a managed care plan with a capped drug benefit for groups as small as one. Premiums for this were lower than for NMCHIP and this caused NMCHIP enrollment to drop. This will change as the Health Alliance will be sunseting this year.

Most recently, there is an issue with the Medicaid program. It has been privatized through managed care organizations (MCOs) three years ago. Initially they were not assessed by the pool. However, it was determined that they should be assessed. Two out of the three MCOs have objected to assessment and they are fighting it in court. The outcome will set a precedent for how other states handle Medicaid MCO assessments.

North Dakota

The Comprehensive Health Association of North Dakota (CHAND) was created by the North Dakota Legislature in 1981. Originally, CHAND was to be self-supporting through collected premiums. However, due to rising claims and premiums, in 1983 the original legislation was amended to limit premiums to 135% of the average premium for standard coverage. In addition, all accident and health insurance companies with at least \$100,000 of annual premium volume received an assessment which is credited against their premium taxes. In 1997 the North Dakota Legislature selected CHAND as its HIPAA alternative.

CHAND has remained stable since its inception. In 1996, the pool deficit was unusually high because no assessments were collected in that year. This was because the IRS had incorrectly informed them that the CHAND was not tax-exempt. Pool administrators opted not to collect assessments until they had finished arguing this matter with the IRS. CHAND was subsequently re-awarded its tax-exempt status.

Enrollment in CHAND declined in the early- to mid-1990s due to small-group insurance reforms. In 1993 the state implemented the NAIC reinsurance model legislation which pertained to groups of 3-25 members. This provided guaranteed issue and renewability and the crediting of prior coverage. In 1997 the scope was increased to groups of 2-50 members. Since the pool became the HIPAA alternative, enrollment has increased slightly.

Oklahoma

The Oklahoma Health Insurance High-risk Pool is a relatively recent pool. It began operation in 1996 and made some minor changes in 1997 in order to use the pool as the state's HIPAA alternative mechanism. Enrollment has steadily grown, from 119 in the pool's first year to 1,600 last year. Pool officials believe this may be due to recent withdrawals in the non-group market.

Pool officials also believe the pool has succeeded in balancing the industry's desire to limit assessments with the members' desire to limit premiums. The pool usually has between a 50/50 and 60/40 split between premiums and assessments. Premiums are set in statute at between 125 and 150 percent of the standard market rate. In practice, the rate started at 125 percent and has been increasing five percentage points with each rate increase. The current board would like to continue that climb to the premium cap of 150 percent.

There have been some additional changes implemented and considered. In late 1997, the benefits package was expanded to include mental/nervous coverage. The Department of Insurance has proposed, for consideration in the current legislative session, increasing the lifetime benefits maximum from \$500,000 to \$1 million. Finally, the insurance industry representatives on the board (five of the nine members) would like to ask the legislature to consider enacting a premium tax offset for the assessment.

Oregon

The Oregon Medical Insurance Pool (OMIP) grew out of broader health reform efforts aimed at reducing the high number of uninsured Oregonians. A study of the uninsured recommended three different approaches—expand Medicaid, mandate employers to offer coverage to their workers, and create a high-risk pool for people denied health insurance because of their health status. The pool was passed in 1987 as one part of the multi-pronged Oregon Health Plan.

OMIP was originally created as a quasi-government agency but without any state funding, which essentially left the insurers to assess themselves. Very little happened until 1989 when OMIP was made a state agency with \$1 million in start-up funds and a board authorized to assess insurers. Premiums are capped at 125 percent for medically-eligible enrollees and 100 percent for portability coverage, among the lowest premiums of all the high-risk pools. Enrollment has steadily grown to about 6,000 and the pool's loss ratios continue to run between 170 to 180 percent.

The most significant challenge to the pool occurred in the early 1990s when SAFECO brought suit to challenge the state's assessment of re-insurers in federal and state courts. The federal case challenged Oregon's authority to assess re-insurers as a violation of ERISA's preemption of self-funded plans. The federal court found that the Oregon statute treats self-funded plans as insureds, not insurers, and that the assessment on re-insurers relates only to insurance companies, not the self-funded plans they insure. The state court upheld Oregon's authority to assess a reinsurer based on the number of lives insured. Together these two rulings established the legality of Oregon's assessment mechanism.

OMIP continues to be an integral part of the state's broader health care strategy. Pool coverage is coordinated with the state's subsidy program, the Family Health Insurance Assistance Program, which was enacted in 1997 and subsidizes coverage for people with incomes up to 170 percent of the federal poverty level.

South Carolina

The South Carolina Health Insurance Pool, which began operation in 1990, has in statute and practice set its premiums at the maximum level suggested by the NAIC model legislation – 200 percent. Enrollment dropped after 1993 and only started climbing again after the pool implemented changes to become the state's HIPAA alternative mechanism. Enrollment today is only slightly higher than it was when the pool started.

The pool's deficit is funded from an assessment with a premium tax offset that is capped at no more than \$5 million. The assessments for 2000 and 2001 were \$4.5 million. If the assessment exceeds \$5 million, the state must fund the excess deficit through so other means. With premiums already at the maximum allowed by law, the board would have to find another way. The Department of Insurance is considering ways to address this issue, including raising the offset cap.

The pool statute calls for the eight-member board to include one person who may be eligible for pool coverage and two representatives of business. As the original appointees for those three positions left

the board, successive governors neglected to appoint new representatives. As a result, the board has only the five industry representatives since March 1998. A board member said the current governor has notified the board that those three positions will be filled shortly.

Texas

Although legislation to create the Texas Health Insurance Risk Pool passed in 1989, no start-up funding was provided. In 1997, sufficient funding was appropriated and the pool began issuing policies in 1998 as the state's HIPAA alternative. In fact, HIPAA was one of the primary reasons for the creation of the pool.

The Texas pool has experienced extremely rapid growth in enrollment, claims, and carrier assessments. As of the end of 2000, enrollment had reached 11,000, up from 6,660 in 1999. Claims grew four-fold between 1998 and 1999, as have assessments. This rapid growth is, perhaps, the biggest threat to the pool as plans have already begun to complain about the size of assessments. As additional evidence of potentially destabilizing growth: premiums have increased each year; they began at 137% of market rates in 1998, increased to 150% and will go up to 165% in 2001.

While nothing explicit has yet been done to tackle problems associated with rapid growth, there is talk of an effort to propose a premium tax credit to offset assessments. In addition, some are considering an enrollment cap for non-HIPAA eligible and assessing stop-loss carriers on a per capita basis. To help control costs, Texas already has contracts with managed care networks and pharmacy benefit managers.

Utah

The Utah Comprehensive Health Insurance Pool was established in 1990 and began operation one year later. The pool is unlike most other pools in that the maximum premium is not set in statute. Instead, the statute requires that premiums not be unreasonable relative to the benefits provided.

The pool is also unusual in its funding mechanism. The bulk of funding comes from premiums, and the balance comes from investment income and state appropriations. The board requests an amount of funding from the legislature and usually receives the requested amount. This year, the pool is funded 60 percent from premiums, 30 percent from state appropriations and 10 percent from investment income. Most pools rely on assessments to fund deficits, but a pool representative said the Utah Legislature dismissed assessments as "the worst possible idea" because using general fund appropriations provides the broadest base.

By statute the pool has the authority to close enrollment in order to control expenditures. This was done in 1997 because the pool board believed its reserves were too low. The pool was reopened in 1998 and enrollment has been climbing 10 percent each year since.

The pool board is currently drafting a strategic plan that will likely have as its second highest goal (after maintaining the integrity of the pool) implementation of a subsidy program. The pool board knows that 40 percent of the people who leave the pool do so because of the cost of coverage. Its

internal data has also shown that potential applicants who don't pursue the application process cite affordability as the reason. There is therefore broad public, board, and governmental support for a low-income subsidy of some kind, particularly to reach the fairly large number of uninsurable people with incomes between Medicaid eligibility levels and 200 percent of the federal poverty level.

Washington

Washington state has a history of health care reform efforts, and those broader efforts have had an effect on who enrolls in the Washington State Health Insurance Pool (WSHIP). The Health Care Access Act passed in 1987; among other provisions, it provided for the creation of WSHIP. Rates were set at a maximum of 150 percent, or 125 percent for those enrolled in managed care plans. Enrollment climbed to a high of 4,400 in 1993.

The Health Reform Act of 1993 sought to achieve universal coverage through comprehensive individual and small group insurance market reform and an employer mandate. With these market reforms, people began moving to the commercial market and enrollment in the pool dropped 70 percent in one year, to 1,300. Those that remained in the pool were the sickest enrollees, typically people with HIV/AIDS or organ transplants, possibly because they didn't trust that the market would remain. The per member cost of the pool climbed as the healthiest enrollees left.

That changed when the market began to change. Many of the reforms enacted in 1993 were repealed in 1995 and the non-group market began to deteriorate. In mid-1999, three large plans left in the same week, leaving only two small plans with scaled-back products in limited areas of the state. The Insurance Commissioner issued a rule that established a new eligibility path to the pool for people in counties without a plan. Enrollment in the pool grew from fewer than 800 enrollees who were primarily Medicare disability-eligibles to 2,200 enrollees who are primarily non-Medicare.

The state sought to revive the non-group market with another set of comprehensive legislation enacted in March 2000. This time, the pool was directly affected by the legislation, with changes in rates and funding. The 2000 legislation establishes discounted premiums for 50 to 64-year olds under 300 percent of the federal poverty level. However, only \$200,000 was appropriated in the biennium for the discounts, so pool officials do not expect many can be covered under this program. The state is currently developing an application process for the discount (which will be administered from a separate agency that has experience with income-based subsidies). Another discount was established to reward tenure in the pool. People who are enrolled in the pool for more than 36 months will qualify for a five percent discount. The legislation also allows the pool to assess stop-loss plans based on one in 10 insured through the plans.

Another provision is expected to directly affect the pool. The legislation allows insurers to use a health screen to send eight percent of applicants to the pool. The screen has recently been put in use but it is too soon to tell how the pool will be affected in terms of enrollment.

Wisconsin

Wisconsin's Health Insurance Risk Sharing Plan (HIRSP) is among the oldest high-risk pools in the nation, established in 1981. It was the first high-risk pool to offer subsidies (beginning in 1985), which are partially funded out of state general revenue. The subsidy program provides a sliding-scale subsidy for premiums for individuals with annual incomes up to \$25,000 (individuals pay 130 percent of the standard rate if their income is between \$10,000 and \$25,000 or 100 percent of the standard rate if their income is \$10,000 or less). Individuals with annual income of up to \$20,000 also qualify for reduced deductibles. The regular \$1000 deductible is reduced on a sliding scale to \$500 for incomes up to \$10,000. The program has been used by about 35 percent of the pool membership, and is funded in part by a state appropriation (\$1.56 million for the 1999/2001 biennium), with the balance funded from assessments and adjustments to provider payments.

HIRSP has experienced several periods of financial instability. Originally, the program could not raise premiums without legislative approval. With the passage of time, premiums became very low relative to market rates, and the high-risk pool began attracting more enrollees than it could afford. Evidence of this can be seen in the pool's financial data. For example, in 1983 HIRSP had an unusually high loss ratio because collected premiums were very low relative to claims and administration costs.

In the early 1990s the funding mechanism was altered by legislation so that the program had to cover a certain amount of its expenses by premiums. This resulted in very rapid premium increases. For example, premiums increased an average of 28% in 1991, 27% in 1992, and 18% in 1993. Such rapid premium increases drove the healthier policy holders from the program and a death spiral commenced: increases in per-enrollee claims outpaced premium increases, necessitating further premium increases which further encouraged healthier enrollees to drop coverage.

In 1998 the legislature enacted a major administrative and financial overhaul of HIRSP. The program was moved from the Department of Insurance to the Department of Health and Family Services. The later oversees the Medicaid program and the motivation was to leverage this administrative capability. The funding mechanism was also substantially altered. The new mechanism consists of four components:

5. The state contributes \$12 million annually from general revenue.
6. Sixty percent of the remaining costs are to be covered by premiums.
7. A portion of the remaining 40% of costs are to be covered by provider discounts.
8. The remaining is funded through assessments.

As a result of the 1998 reforms the program seems to be on a much more stable financial basis. In fact, funding has outpaced expenses in recent years, which might create pressure to reduce premiums and/or to cut assessments and general revenue contributions.

Wyoming

The Wyoming Health Insurance pool began operating in 1991 as one program with two different plans, a higher deductible/lower lifetime maximum plan known as the Brown Plan and a lower deductible/higher lifetime maximum plans known as the Gold Plan. In 1992, legislators received calls from people in the Medicare disabled community who said they couldn't obtain Medicare supplemental coverage because they were denied. As a result, the Legislature created a "coordination of benefits" plan for Medicare disabled individuals. The highest enrollment is in the Gold Medicare Disabled Plan (lower deductible/higher lifetime maximum).

The pool started operation with an initial flat-amount assessment and then didn't do another assessment for three years (another flat-amount assessment because they weren't tracking premium volume). In 1994, when the reserve started getting low, the board looked at what other states were using to finance its pools. As a result, the legislature authorized the board to assess insurers as many times as necessary, for which insurers would receive an 80 percent premium tax offset, up to \$1 million in total assessment.

Premiums were originally allowed by statute to go up to 200 percent of the market rate. When premiums were increased in the first years of pool operation, enrollment dropped slightly. In 1995, the legislature lowered the premium range to between 125 and 150 percent of the standard market rate. The premium is currently at 147 percent. Since premiums were lowered, enrollment has steadily climbed from 200 enrollees at the old rates to 570 under the current premium range.

At the same time, the legislature increased the cap on the offset to \$1.625 million, with an 80 percent credit allowed against the first \$1.25 million of the total assessment and 50 percent credit against the second \$1.25 million of total assessment. Beyond \$2.5 million no credit is allowed. Assessments to date have not exceeded this amount. The board believes this approach – an assessment with a partial offset – allows the consumers, insurers, and state to share in the cost of pool coverage. Furthermore, this approach ensures the state knows what its risk will be (but the insurance companies do not).

Appendix B: Legal Analysis

NAIC Model Legislation (as revised 10/99)	Alabama ¹	Alaska	Arkansas	California	Colorado	Connecticut	Florida	Illinois	Indiana	Iowa	Kansas	Louisiana	Minnesota	Mississippi	Missouri	Montana	Nebraska	New Mexico	North Dakota	Oklahoma	Oregon	South Carolina	Texas	Utah	Washington	Wisconsin	Wyoming
SECTION 1: Definitions																											
"Church Plan"			X				X	X	X	X	X	X					X ³⁴	X ²³		X ²³		X ²³				X	
"Creditable Coverage"			X		X ⁴³		X	X ⁵	X	X	X	X ¹²					X	X		X		X				X	X
A group health plan			X				X		X	X	X						X	X		X		X				X	
Health insurance coverage			X				X		X	X							X	X		X		X				X	
Part A or Part B of Title XVIII of the SSA (Medicare)			X				X		X	X	X						X	X		X		X				X	
Title XIX of the SSA (Medicaid)			X				X		X ⁶	X							X	X		X		X				X	
Chapter 55 of Title 10, US Code							X		X	X							X	X		X		X				X	
A Medical care program of the Indian Health Services or of a tribal organization			X				X		X	X							X	X		X		X					
A state health benefits risk pool			X				X		X	X							X	X		X		X					
A health plan offered under Chapter 89 of Title 5, US Code			X				X		X	X							X	X		X		X					
Public health plan as defined in federal regulations			X				X		X	X							X	X		X		X					
Health benefit plan under section 5(e) of the Peace Corps Act			X				X		X	X							X	X		X		X					
"Dependent"	X			X			X		X	X	X	X	X	X								X	X				
"Federally Defined Eligible Individual"		X	X				X	X	X	X	X	X ¹³				X			X	X		X				X	X
Creditable coverage 18+ months	regs		X				X	X	X	X						X			X	X		X				X	X
Prior creditable coverage	regs		X				X	X	X	X						X			X	X		X				X	X
Not eligible for coverage under a group health plan, Medicare or Medicaid	regs		X				X	X	X	X						X			X	X		X				X	X
Coverage not terminated due to nonpayment of premiums or fraud	regs		X				X	X	X	X						X			X			X				X	X
Exhausted COBRA	regs		X				X	X	X	X						X			X	X		X				X	X
"Health Insurance Coverage"	regs	X	X	X		X	X	X	X	X		X	X			X	X					X	X	X	X	X	X
"Insurer"--any entity that provides health insurance coverage	regs		X			X	X			X	X	X				X	X	X	X	X	X	X	X	X		X	X
"Resident"--30 days minimum			X	X		X	X							X ²⁰									X			X	
"Significant Break In Coverage"--63 days	regs																										

	Alabama ¹	Alaska	Arkansas	California	Colorado	Connecticut	Florida	Illinois	Indiana	Iowa	Kansas	Louisiana	Minnesota	Mississippi	Missouri	Montana	Nebraska	New Mexico	North Dakota	Oklahoma	Oregon	South Carolina	Texas	Utah	Washington	Wisconsin	Wyoming
NAIC Model Legislation (as revised 10/99)																											
SECTION 2: Operation of the Plan																											
Insurance Commissioner on Board	regs	X	X		X		X			X		X						X ²⁴	X					X	X	X	X
2+ Eligibles on Board		X			X			X	X			2	X				X ³⁵	X		X ²⁷		X ²⁸	X	X		X	
2+ Insurers on Board	regs		X		X ³³		X ⁴²		X ⁶	X ⁹		X ¹⁴	X ³⁸	X ²¹	X ³³	X ³⁸	X ³⁶	X ²⁵	X ³³	X	X	X	X	X	X ⁴²	X ³²	X ³³
Majority of Board not industry or provider																		X									
Initial Board Terms Staggered	regs				X		X	X				X		X				X		X			X	X	X		X
Board members shall not be compensated	regs	X	X		X	X	X	X	X	X	X	X	X	X		X		X	X	X	X			X	X		X
Board submits plan/amendments to Commissioner	regs	X			X	X	X		X	X	X	X			X		X	X		X		X		X	X		X
If board fails, Commissioner can issue rules	regs	X			X	X	X		X	X	X	X			X		X	X		X		X		X	X		X
Plan of operation:																	X										
Procedures for selecting an administrator	regs		X		X	X		X						X	X		X	X		X	X	X	X	X	X		X
Procedures to create a fund	regs	X	X					X			X										X		X				
Develop and implement a marketing program	regs	X	X		X		X	X	X	X	X	X	X	X			X	X	X	X		X	X	X	X	X	X
Establish grievances procedure	regs	X ⁵³	X		X		X	X						X									X		X	X	
General powers and authority:		X																									
Establish and modify rates, agents' fees, claim reserve formulas	X	X	X		X	X		X	X	X	X	X		X	X		X	X			X	X	X	X	X		X
Rates may be adjusted for age, sex, and geographic variation	X	X	X		X			X			X	X		X	X		X	X			X				X		X
Borrow money for plan	X	X	X		X			X						X		X	X					X	X				
Provide optional coverages including Medicare supplemental insurance	regs ²	X	X					X						X		X										X	
Annual report to the Governor also filed with the legislature	regs	X ⁵⁴			X ³⁷	X ³⁷	X	X		X ¹⁰	X ¹¹	X ¹⁵		X ²²									X	X ³⁰	X ³⁷	X ²²	
SECTION 3: Establishment of Rules					X																						
SECTION 4: Eligibility																											
Any resident shall be eligible if evidence of:																											
Notice of rejection	regs		X	X	X		X	X	X	X	X			X	X		X	X		X	X	X	X	X	X	X	X
Refusal except at a rate exceeding the plan rate			X	X	X		X	X	X	X	X			X	X ⁴¹		X	X		X		X	X	X			X
Any federally defined eligible		X	X					X	X	X	X	X								X		X				X	X
Rejection by stop loss, excess of loss, or reinsurance not sufficient			X					X		X													X				
By virtue of list of health conditions					X			X		X							X				X		X	X		X	
Can maintain coverage to satisfy PEC			X		X				X		X			X				X					X				
months have lapsed			X		X			X	X ⁷	X					X		X			X	X	X	X	X	X	X	X
Ineligible if reached lifetime maximum benefits			X	X	X		X	X							X		X		X	X	X	X		X	X	X	X
Can't use government money to pay premium			X					X		X				X									X			X	
Lifetime benefits limit set		X	X	X	X		X	X			X	X	X	X	X	X	X		X	X	X	X		X	X	X	X
Amount of lifetime benefit		\$1M	\$1M	\$750k	\$500k		\$500k	\$1M			\$1M	X ¹⁶	\$2.8M	\$250k	\$1M	X ³⁹	\$1M		\$1M	\$500k	\$1M	\$1M		\$1M	\$1M	\$1M	\$500k

	Alabama ¹	Alaska	Arkansas	California	Colorado	Connecticut	Florida	Illinois	Indiana	Iowa	Kansas	Louisiana	Minnesota	Mississippi	Missouri	Montana	Nebraska	New Mexico	North Dakota	Oklahoma	Oregon	South Carolina	Texas	Utah	Washington	Wisconsin	Wyoming
NAIC Model Legislation (as revised 10/99)																X											
SECTION 5: Unfair Referral to Plan																X											
SECTION 6: Plan Administrator																											
Qualifications	regs	X	X					X			X	X	X	X	X		X	X		X	X	X	X	X	X		X
Period of contract	regs		3 yrs		3yrs			5 yrs			3 yrs	3 yrs	3yrs	3 yrs	3yrs	3yrs	3yrs	3 yrs	3yrs	2yrs	3yrs	3yrs	3yrs	3yrs	3yrs		3yrs
Functions	regs	X	X		X			X				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
SECTION 7: Funding of the Plan																											
Premiums	regs																										
Minimum (125-150)	125		150	125		125		125				X ¹⁷	101	150	150	135		100 ²⁶		125			125		110	150	125
Maximum (200)	200	200	200	135	150	150	X ⁴⁴	150	150	150	150	200	125	175	200	200	135	150	135	150	125	200	200	X ³¹	150	200	200
Additional Revenue																											
Assessment based on premium share	X	X	X					X ⁵⁵	X	X	X		X		X			X	X	X	X	X	X			X	X
Assessment of health insurers and reinsurers based on number of persons they cover														X		X									X		
offset	X		X ⁴⁶						X	X ⁴⁷	X ⁴⁸		X		X	X	X ⁴⁹	X ⁵⁰	X			X ⁵¹			X		X ⁵²
stoploss included			X											X							X ⁵⁷		X ⁵⁷		X ⁵⁷		
excess included														X													
Service charge on hospital and surgical centers																											
Appropriation of General Revenue								X ⁵⁶																			
Other Sources																											
SECTION 8: Benefits																											
Board authority to determine	X				X			X	X		X			X	X		X	X			X	X	X	X			X
List in statute		X	X	X				X	X	X	X	X	X			X			X	X					X	X	
Adjust deductibles annually																	X				X					X	
PEC exclusion (6 months)		X ⁴	X	X ⁴⁵	X			X	X ¹⁹	X	X	X ¹⁸	X	X	X ⁴⁰	X ⁴⁰	X		X		X		X ²⁹		X	X	

Notes

1. By and large, high-risk pools are governed by state statutes. However, Alabama is the only state with regulations substantially governing the operation of the pool. Those provisions are reflected in this table.
2. No period of time given
3. Medicare not mentioned
4. Three months
5. As defined in Health Insurance Portability and Accountability Act
6. Three insurers
7. Six months
8. Other than coverage consisting solely of benefits under section 1928 of that Act
9. Seven carriers of individual health insurance
10. Just financial report to legislature
11. Report to Commissioner then legislature
12. As defined by RS 22:250.1(4)
13. As defined by RS 22:250.12(B)
14. Several Insurers
15. Just to legislature
16. Not less than \$500,000 lifetime and not more than \$100,000 per 12 months per covered individual
17. 125% or rates established for other individuals provided coverage by or through the plan unless such rates would exceed 200%
18. No time limit specified
19. Three months
20. Not less than six months and not greater than one year
21. At least four of nine
22. Report to legislature only
23. As defined in 59A-23E-2 NMSA 1978
24. "Superintendent or designee"
25. Four of nine members
26. Based on income
27. One eligible
28. One eligible
29. Twelve months
30. Annual budget report to legislature and report to commissioner
31. May not exceed expected claims and expenses of individual
32. Four of twelve
33. Three insurers
34. As defined in 29 USC 1002
35. One eligible
36. Four insurers
37. Financial report to commissioner
38. Five insurers
39. At least \$500,000

40. Twelve months
41. Three times the standard rate
42. One insurer
43. Called “Qualifying previous coverage” defined in 10-16-102(13.7) Colorado State Code
44. 200% for low-risk individuals, 225% for middle-risk individuals, and 250% for high-risk individuals
45. Ninety days
46. May not be assessed an amount greater than previous year’s premium tax
47. Offset limited to 20% per year for five years
48. Offsets allowed for 60% of total assessment (down from 80% when pool began).
49. Limited to total tax liability, receive credit above this amount
50. Cap at 30%
51. Cap at \$5 million
52. Cap at \$1.625 million (80% of first \$1.25 million, 50% of next \$1.25 million)
53. Grievance process for member insurers only, not enrollees.
54. Report due to Governor only, at least once every three years.
55. Assessment is for HIPAA pool only.
56. General Revenue is for non-HIPAA pool only.
57. Included in definition of “insurance” or “insurer” in statute.

Appendix C: Networking Guide

NETWORKING GUIDE FOR INITIAL CALLS

WITH STATE INSURANCE OFFICIALS & PLAN ADMINISTRATORS

Note: This is a list of potential questions/topics for discussion between Abt Associates staff and State Insurance Officials and plan administrators in the states with high-risk pools. The format is purposefully informal. These are topic areas that may lead to more in-depth discussion on any given topic. Please see the note at the end of the guide for additional content areas to cover.

CALL DATE:

CALL TIME:

DISCUSSANT:

TITLE:

ORGANIZATION:

PHONE:

e-mail:

ABT STAFF CONDUCTING CALL:

I am with Abt Associates, a private research firm based in Cambridge, Massachusetts. The Health Care Financing Administration has asked us to help them better understand how states are using high-risk pools as a way of ensuring portability of health insurance and in achieving HIPAA compliance. [If state is not using HIPAA as their alternative mechanism you can say, "I realize your state is not using the pool as the alternative mechanism but it would help us to have a better understanding of pools in general."] I would like to talk with you for a few minutes about your state's implementation of the high-risk pool and particularly ask you about sources of information that might enable us to study your state's high-risk pool in more depth. This will take about 45 minutes to an hour. Do you have any questions before we begin?

Thank you.

Background and Legislative History of High-Risk Pool in Your State	
Before I ask questions, I want you to be aware that I have reviewed the information about your state's high-risk pool in Communicating for Agriculture's annual summary as background for this interview. Do you know of any other information resources that would be helpful such as annual reports, or research studies?	
I understand that your plan became operational in _____. Could you give me a thumbnail sketch of the legislative landscape with regards to your state's high-risk pool?	
Were there any periods of instability in the pool? For example, rapid growth? Significant withdrawals by carriers in your state? What about closures by major groups (e.g., plant closings)? How is your state's pool doing now? (enrollment? Covering target population? Financial stability? Operational issues?) What about the non-group health insurance market?	
Has the instability described above resulted in changes in the pool either through legislation or through operation changes or other board action?	
Have there been any small group insurance reforms?	
Is there any other legislation on the horizon that might impact the high-risk pool in your state?	
Could you describe the political circumstances that led to the creation of the high-risk pool in your state? (Probe: was this a response to a crisis? Proposed a new benefit? Were alternatives considered?)	

What kinds of modifications were implemented in your state's pool prior to HIPAA?	
What role did HIPAA legislation play in bringing about the state level legislation that (created) modified the high-risk pool?	
[For states not using pool as HIPAA mechanism] Could you discuss why your state has chosen not to utilize the pool as its HIPAA alternative mechanism? If you don't know, could you suggest someone I could talk with who might be able to explain?	
Funding and Premiums	
According to Communicating for Agriculture, your plan is financed by _____. Were or have other mechanisms been considered? To what extent does the financing method limit enrollment or hinder growth? Has HIPAA impacted the financing mechanism in your state?	
What is your premium percentage? What is the history of the premium percentage? Could you describe your premiums in terms of actual premiums as compared to the cap? (note make sure to clarify changes in cap and premium over time)	
Does your pool assess stop-loss insurers? (If so, find out 1. How they've structured the assessment so that it could withstand an ERISA challenge, and 2. Do they assess the carriers based on their premiums or # of lives covered?) If not, are there any plans to do so in the future?	
Cost Containment in the High-Risk Pool in Your State	

Does your pool have HMO or PPO options as cost containment measures? How do they work?	
Does your pool use case managers for your most costly enrollees?	
What about disease management programs? Does your plan use any of these? Have you considered these or other cost containment mechanisms?	
Does your plan offer a drug benefit? [Don't ask if obvious].	
Do you have tiered copays for drugs? What kind of co-insurance applies to drugs? Do drug cost-sharing payments count against an individual's stop-loss (out-of-pocket max)? Do you use a formulary? What about a Prescription Benefit Manager? If not, do you get any discounts on drug costs? Do you have any plans for future steps to control drug costs?	
Access to the High-Risk Pool in Your State	
What is the composition of your board? Are there consumer representatives? If so, how are they selected? Does the industry have a majority?	
Does your pool have any caps on enrollment or waiting lists? What keeps the pool at its current size?	
Does your pool offer any subsidy programs? ? If not, are there any plans to do so in the future?	
How do potential enrollees find out about your pool? Does your plan use any particular methods or materials for marketing and consumer education about the plan? To HIPAA eligibles? Can people enroll directly or only through an agent? In general? Is there anything else your plan is doing to promote access?	

Does your pool require prior group insurance?	
Information Resources in Your State	
Could we obtain copies of your original statutes and your current statutes which authorize the high-risk pool?	
Other than yourself, who would you say are the 3 most knowledgeable people in your state about your high-risk insurance pool?	
Is there anyone else in the plan or in the state agency that you have not already mentioned who would be informative for us to talk to?	
Key Stakeholders in Your State	
Are there any key stakeholders in your state concerning the uninsured and the high-risk insurance plan? (Examples for probing: consumer groups, insurance industry, political groups)	

Appendix D: Risk-Pool Web Sites

State	Agency	Web Site
Alabama	Alabama Health Insurance Plan	http://www.probenefits.com/VF/Alabama.htm
Alaska	Alaska Comprehensive Health Insurance Association	http://www.achia.com
Arkansas	Arkansas Comprehensive Health Insurance Plan	None
California	California Managed Risk Medical Insurance Program	http://www.mrmib.ca.gov/
Colorado	Colorado Uninsurable Health Insurance Plan	http://www.cuhip.com/
Connecticut	Connecticut Health Reinsurance Association	None
Florida	Florida Comprehensive Health Insurance Plan	http://www.publicpurpose.org/fcha
Illinois	Illinois Comprehensive Health Insurance Plan	Http://www.state.il.us/ins/chip.htm
Indiana	Indiana Comprehensive Health Insurance Association	Http://www.onlinehealthplan.com/oasys/ (connection from here depends on membership status and state)
Iowa	Iowa Comprehensive Health Association	Http://www.onlinehealthplan.com/oasys/ (connection from here depends on membership status and state)
Kansas	Kansas Uninsurable Health Insurance Plan	http://www.benefitmanagementks.com/khia
Louisiana	Louisiana Health Insurance Association	http://www.lahealthplan.org
Minnesota	Minnesota Comprehensive Health Association	http://www.mchamn.com/
Mississippi	Mississippi Comprehensive Health Insurance Risk Pool	http://www.doi.state.ms.us/mc_hirpa.html
Missouri	Missouri Health Insurance Pool	http://www.insurance.state.mo.us/consumer/lhindex.htm
Montana	Montana Comprehensive Health Insurance Association	None
Nebraska	Nebraska Comprehensive Health Association	None
New Mexico	New Mexico Comprehensive	http://aidsinfonet.org/322-

State	Agency	Web Site
	Health Insurance Pool	chip.html
North Dakota	Comprehensive Health Association of North Dakota	http://www.chand.org/
Oklahoma	Oklahoma Health Insurance High-Risk Pool	None
Oregon	Oregon Medical Insurance Pool	http://www.cbs.state.or.us/external/omip/index.html
South Carolina	South Carolina Health Insurance Pool	None
Tennessee	TennCare Program	http://www.state.tn.us/health/tenncare/
Texas	Texas Health Insurance Risk Pool	http://www.txhealthpool.com/
Utah	Utah Comprehensive Health Insurance Pool	http://www.bcbsutah.com/
Washington	Washington State Health Insurance Pool	http://www.onlinehealthplan.com/oasys/ (connection from here depends on membership status and state)
Wisconsin	Wisconsin Health Insurance Risk Sharing Plan	http://www.dhfs.state.wi.us/hirsp/index.htm
Wyoming	Wyoming Health Insurance Pool	None

Appendix E: Risk-Pool Financing Mechanisms

State	Assessment	Stop-Loss (per capita or premium share)	Offset		Provider tax	Other source	Premium	
			Offset?	Full or partial? If partial, % or \$ cap?			Statutory Range	Actual
Alabama	Yes	No	Yes	Full	No	No	200% cap	175%
Alaska	Yes	Yes, premium share	No	N/A	No	N/A	200% cap	started at 175%, now at 150%
Arkansas	Yes	Yes, premium share	Yes	Full	No	N/A	150-200%	
California	No	No	No	N/A	No	Cigarette tax.	125% cap	125%
Colorado	No, but legislation under consideration	No	No	N/A	No	Interest from unclaimed property	150% cap	119%
Connecticut	Yes	No	No	N/A	No	N/A	125-150%	150%
Florida	Yes	No	None now; had offset until 1989	N/A	No	N/A	Up to 250% for high risk, 225% for med, 200% for low	Varies with risk
Illinois	For HIPAA pool only.	Yes, premium share	No	N/A	No	General revenue for non-HIPAA pool.	125-150%	135%
Indiana	Yes	No	Yes	Full	No	N/A	150% cap	150%
Iowa	Yes	No	Yes	Full but limited to 20%/yr for 5 years	No	N/A	150% cap	150%

State	Assessment	Stop-Loss (per capita or premium share)	Offset		Provider tax	Other source	Premium	
			Offset?	Full or partial? If partial, % or \$ cap?			Statutory Range	Actual
Kansas	Yes	Yes, premium share	Yes	Partial, capped at 60% (started at 80%)	No	N/A	150% cap	138%
Louisiana	Yes, for HIPAA pool; general revenue for non-HIPAA pool	No, but discussions to include	No	N/A	No	N/A	125-200%	200%
Minnesota	Yes	Yes, premium share	Yes	Full	Yes, indirectly	Surplus funds from the Minnesota's Workers Compensation Assigned Risk Plan. This funding mechanism has been challenged as unconstitutional and the case is still pending.	125% cap	125%
Mississippi	Yes	Re-insurers, per capita; assessed on "honor system" of plans self-reporting but working on survey process	No	N/A	No	N/A	150-175%	150%
Missouri	Yes	Yes, premium share	Yes	Full	No	N/A	200% cap	Premiums unchanged last 2 years, so rate as % has dropped to 183%

State	Assessment	Stop-Loss (per capita or premium share)	Offset		Provider tax	Other source	Premium	
			Offset?	Full or partial? If partial, % or \$ cap?			Statutory Range	Actual
Montana	Yes	No	Yes	Full	No	N/A	200% cap (150% for HIPAA eligibles)	200%
Nebraska	Yes, until 2001 when changed to general revenue (from premium taxes)	No	Yes, until 2001 when financing changed		No	As of 1/2001, premium taxes	135% cap	135%
New Mexico	Yes	No	Yes	Partial, capped at 30%	No	No	150% cap	125%
North Dakota	Yes	No	Yes	Full	No	No	135% cap	135%
Oklahoma	Yes	No	No	N/A	No	N/A	125-150	140%
Oregon	Yes	Yes, "re-insurers", per capita	No	N/A	No	Interest on reserves (2% of funding)	125% cap for medical eligible; 100% for portability coverage	125%/100%
South Carolina	Yes	No	Yes	In statute partial offset capped at \$5m; in practice full offset because assessment less than \$5m	No	N/A	200% cap	200%

State	Assessment	Stop-Loss (per capita or premium share)	Offset		Provider tax	Other source	Premium	
			Offset?	Full or partial? If partial, % or \$ cap?			Statutory Range	Actual
Texas	Yes	Yes, premium share	No	N/A	No	No	200% cap	150% in 2000 (up from 165% in 2001)
Utah	No	N/A	N/A	N/A	No	30% from general revenue, 10% investment income, 60% premiums	None in statute; "can't exceed actual expenses"	N/A
Washington	Yes	Yes, since 3/2000 legislative changes; assessed on per capita basis at rate of 1 life per 10 covered by stop-loss plan	Yes	Full	No	N/A	150% cap, 125% for managed care	150%/125%
Wisconsin	Yes	Yes, premium share	No	N/A	Provider discounts	General revenue	200% cap	150%
Wyoming	Yes	No	Yes	Partial, capped at \$1.625m (80% on 1 st \$1.25m, 50% on 2 nd \$1.25m, none above \$2.5m)	No	N/A	125-150% (down from 200%)	Approx. 150%

Appendix F: State-Level Multivariate Results

Simulation: Estimated Effect on Pool Enrollment of Reducing Premium to \$118				
State	Premium, Actual	Enrollment, Actual	enrollment simulations: \$118 premium	
			Spec 1	Spec 2
AK	\$389	268	932	2840
AL	\$170	1773	2596	3652
AR	\$149	1675	2137	2658
CA	\$245	20834	44682	88441
CO	\$208	1020	1844	3132
IL	\$280	7786	19197	43048
KS	\$333	1202	3552	9366
MN	\$118	25433	25433	25433
MS	\$209	2017	3664	6252
MT	\$243	1343	2856	5609
ND	\$201	1302	2271	3736
NM	\$196	1030	1750	2812
OK	\$188	1195	1944	3004
TX	\$191	6660	11013	17273
WA	\$259	1065	2421	5046
All	mean = \$225	75,000	126,000	222,000
<i>Includes states that reported individual premium only</i>				

Simulation: Estimated Effect on Pool Enrollment of Reducing Premium to 125 Percent of Market

State	Premium as percent of market, actual	Enrollment, actual	enrollment simulation: 125 percent of market	
			Spec 3:	Spec 4
AK	200%	268	506	743
AL	200%	1773	3347	4919
AR	150%	1675	2143	2488
CA	125%	20834	20834	20834
CO	150%	1020	1305	1515
CT	125%	1726	1726	1726
FL	250%	811	2070	3652
IA	150%	336	430	499
IL	125%	7786	7786	7786
IN	150%	4513	5775	6705
LA	125%	1026	1026	1026
MN	125%	25433	25433	25433
MO	150%	761	974	1131
MS	150%	2017	2581	2996
MT	150%	1343	1718	1995
ND	135%	1302	1445	1539
NE	135%	4653	5163	5499
NM	125%	1030	1030	1030
OK	150%	1195	1529	1775
OR	125%	5822	5822	5822
SC	200%	1210	2284	3357
TX	150%	6660	8522	9894
WA	150%	1065	1363	1582
WI	200%	7904	14922	21927
All states (26) ^A	mean = 154%	102,000	120,000	136,000

A KS excluded because KS did not report percent of market.

Sources: Abt using data from Communicating for Agriculture, the CPS, Statistical Abstract.